1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14246

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 5021 Laguna Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: J — Last: Adams

4. DATE OF DEATH: Month: 10 — Day: 31 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4 Feb. 1896
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHARMACIST
10b. KIND OF BUSINESS OR INDUSTRY: DRUG STORE
11. BIRTHPLACE (State or foreign country): TENNESSEE
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: NOAH ADAMS
14. MOTHER'S MAIDEN NAME: LAURA WESTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 241 14 3393
17. INFORMANT: RALPH M. MOORE — Address: SAME AS #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus - over 1 year.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 10-31-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: NOV 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: Oakwood Cemetery
23d. LOCATION (City or Town) (County) (State): CHARLOTTESVILLE VIRGINIA

24. FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: RIVERDALE, MD.
25a. REC'D BY REGISTRAR DATE: NOV 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

7 1

FOR STATE HEALTH DEPT.

M

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99

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14242

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14247

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 7930 15th. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ray — Middle: E — Last: Anderson
4. DATE OF DEATH: Month: 10 — Day: 8 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 April 1911
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: carpenter
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: John Lee Anderson sr
14. MOTHER'S MAIDEN NAME: Bessie Edwards
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 225 05 1653
17. INFORMANT: Evelyn Mae Anderson — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: over 2 yrs
DUE TO Carcinoma of the pharynx — over 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 10-9-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 11, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Washington National
23d. LOCATION (City or Town) (County) (State): Suitland Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE OCT 11 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

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M

14248

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges · MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5805 Ravenswood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary · Middle: L · Last: Bakersmith
4. DATE OF DEATH: Month: Oct. · Day: 15 · Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ Sep. DIVORCED ☐
8. DATE OF BIRTH: 14 Sept., 1924
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months · Days
IF UNDER 24 HRS.: Hours · Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): W. VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME: RALPH KARNES
14. MOTHER'S MAIDEN NAME: VINNA BENSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 443261303
17. INFORMANT: ALOUISE RICKERAL S · Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — Acute pulmonary edema, severe
DUE TO (b): Congestive heart failure
DUE TO (c): Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lupus erythematosus; Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Oct. 13, 1967, to Oct. 15, 1967, that (I) (we) last saw the deceased alive on Oct. 15, 1967, and that death occurred at 2.05 AM from causes and on the date stated above.

22a. SIGNATURE: Fidel J. Quintana M.D. · ATTENDING PHYS. ☒ · MED. DIRECTOR ☐ · STAFF PHYS. ☐
22b. DATE SIGNED: Oct. 15, 1967
22c. PHYSICIAN'S NAME (Type): Fidel J. Quintana, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT 19, 1967
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM
23d. LOCATION (City or Town) (County) (State): BLADENSBURG, MARYLAND
24. FUNERAL DIRECTOR: W. W. Chambers Co. · ADDRESS: RIVERDALE, MD
25a. REC'D BY REGISTRAR DATE: OCT 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14244

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14249

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 45 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont Heights
d. STREET ADDRESS: 5713 Jay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Vernon — Middle: W — Last: Barnett

4. DATE OF DEATH: Month: 10 — Day: 30 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 23 April 1911

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Vernon W Barnett Sr

14. MOTHER'S MAIDEN NAME: Rosa Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW2

16. SOCIAL SECURITY NO.: 579-01-5706

17. INFORMANT: Mrs Dorothy B. White — Address: 29-42nd st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH: over 1 hr.
331X
DUE TO (b) Hypertensive cerebro vascular disease — unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John Kehoe M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale Md.

22. DATE SIGNED: 10-31-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-3-1967

23c. NAME OF CEMETERY OR CREMATORY: Harmony

23d. LOCATION (City or Town) (County) (State): Highland Park Md

24. FUNERAL DIRECTOR: H.S. Washington & Sons — ADDRESS: 4925 Benning Ave NE

25a. REC'D BY REGISTRAR — DATE: NOV 3 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

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14245

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14250

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Pr Geo
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN MARYLAND: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo Gen Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 6915 Carlton Terrace
d. STREET ADDRESS: College Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCES Middle M Last BAUER
4. DATE OF DEATH: Month Oct Day 15 Year 1967
5. SEX: Fe
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 29, 1888
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM J. BARNARD
14. MOTHER'S MAIDEN NAME: UNK — (HEWITT)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: John W Bauer (Husband) Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
332x
DUE TO (b): Hypertensive Arteriosclerotic
DUE TO (c): Cerebral Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 10-6, 1967, to Oct, 1967, that (I) (we) last saw the deceased alive on 10-14 1967, and that death accurred at 12:30 M, from causes and on the date stated above.

22a. SIGNATURE: W L Etienne M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-15-67
22c. PHYSICIAN'S NAME (Type): W. L. ETIENNE
22d. ADDRESS: College Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Oct 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: ASBURY CEM
23d. LOCATION (City or Town) (County) (State): PERRYVILLE MARYLAND

24. FUNERAL DIRECTOR: W. W. CHAMBERS Co
ADDRESS: RIVERDALE, MD
25a. REC'D BY REGISTRAR DATE OCT 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Chambers Nathan

1

14246

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 1/2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights
d. STREET ADDRESS: 2506 Iverson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: T. — Last: Beach
4. DATE OF DEATH: Month: Oct. — Day: 12 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 9/27/13
9. AGE (In years last birthday): 54 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINTENENCE MAN
10b. KIND OF BUSINESS OR INDUSTRY: BERTRENS REAL EST
11. BIRTHPLACE (County & State or foreign country): WASHINGTON D.C
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME: EDWARD W. BEACH
14. MOTHER'S MAIDEN NAME: SARAH BURNETT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 578-16-6638
17. INFORMANT: EMILIE TAVAROZA — Address: 6012 NAVAL AV LANHAM, MD. 20801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Cerebral atherosclerosis
DUE TO
(c): Generalized atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Stenosing arteriosclerosis of the coronary arteries
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Sept. 29, 1967, to Oct. 12, 1967, that (I) (X) last saw the deceased alive on Oct. 12, 1967, and that death occurred at 11:10 AM, from causes and on the date stated above

22a. SIGNATURE: Fidel J. Quintana — M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Fidel Quintana, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Oct 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM
23d. LOCATION (City or Town) (County) (State): SUITLAND, MARYLAND
24. FUNERAL DIRECTOR: W. W. CHAMBERS, Co. — ADDRESS: RIVERDALE MD
25a. REC'D BY REGISTRAR: DATE OCT 18 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4) 25M 1/67

4

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14247 — 14252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner Dr John Kehoe Pro Geo County Md notified and approved

1. PLACE OF DEATH
a. COUNTY: Prince George's County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
c. LENGTH OF STAY IN 1b: 25 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8 M Southway Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
d. STREET ADDRESS: 8 M Southway Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adelina — Middle: Marie — Last: Beck

4. DATE OF DEATH: Month: October — Day: 28 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 6, 1910

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Snyder, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Enrico Barili

14. MOTHER'S MAIDEN NAME: Katie Trutt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Husband and Mother — Address: 8 M Southway Rd. Greenbelt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Metastatic carcinosarcoma — 3 years
DUE TO (c): Carcinosarcoma of uterus — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September, 1967, to October 28, 1967, that (I) (we) last saw the deceased alive on October 15 1967, and that death occurred at 9:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert S. Wilkinson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: October 28, 1967

22c. PHYSICIAN'S NAME (Type): Robert S. Wilkinson, M.D.

22d. ADDRESS: 2121 Pennsylvania Ave, N.W. Washington DC 20037

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/31/67

23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery

23d. LOCATION (City, town or county) (State): Selinsgrove Pa.

24. FUNERAL DIRECTOR: Francis Gasch's Sons — ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: OCT 31 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

jwb

VR A15 (4)
15M 4-64

4 1

14249

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14253

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md
b. COUNTY: Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, Md.
d. STREET ADDRESS: 3814 Oglethrope st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-1

3 NAME OF DECEASED (Type or print): First: Iphigenia; Middle: ; Last: Beller

4 DATE OF DEATH: Month: Oct.; Day: 24; Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: July 18, 1872
9. AGE (In years last birthday): 95 yrs
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): Washington D. C.
12 CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Young
14. MOTHER'S MAIDEN NAME: Martha Ritchie

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --
(If yes give war or dates of service):
16 SOCIAL SECURITY NO.: --
17 INFORMANT: Margaret Beller — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 mins
DUE TO
(b) Bilateral Lobar Pneumonia — 14 Days
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 10, 1967 to Oct. 24, 1967, that (I) (we) last saw the deceased alive on Oct. 24 1967, and that death occurred at 4:45 P.M. from causes and on the date stated above.

22a SIGNATURE: Charles C. Hageage M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Oct. 24, 1967
22c. PHYSICIAN'S NAME (Type): Charles C Hageage
22d. ADDRESS: Mt Rainier--, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 27, 1967
23c NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery
23d LOCATION (City or Town) (County) (State): Colmar Manor Pro George Md.

24 FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 30 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14243

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14254

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PRINCE GEORGE GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVERDALE 16 1
d. STREET ADDRESS: 5000 Queensbury Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hanawalt — Middle E — Last Bennett
4. DATE OF DEATH: Month OCT — Day 16 — Year 1967
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 24, 1901
9. AGE (In years last birthday): 65 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired stock Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Gas Light co
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Loyal P Bennett
14. MOTHER'S MAIDEN NAME: Ida M. Simmons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 214 01 0267
17. INFORMANT: Doris R Bennett — Address: Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HT FAILURE
DUE TO (b): BIL BRONCHOPNEUMONIA
DUE TO (c): CARCINOMATOSIS — BRONCHOGENIC CARCINOMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 1 YR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 2 ANEMIA
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to Oct, 1967, that (I) (we) last saw the deceased alive on Oct 9 1967, and that death occurred at 11 A M, from causes and on the date stated above

22a. SIGNATURE: Benjamin S. Miller — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Benjamin S. Miller
22d. ADDRESS: Mt Rainer, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 19, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons Hyattsville, Md. — ADDRESS
25a. RECD BY REGISTRAR — DATE: OCT 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Prince Geo. Co. Med. Examiner notified and released

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14250

CERTIFICATE OF DEATH

14255

1 PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 709 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Glenn Dale Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: D.C. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 141 Anacostia Rd., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: L. Last: Berry
4. DATE OF DEATH: Month: 10 Day: 20 Year: 19 67
5. SEX: ~~MALE~~ F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/4/88
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (County & State, or foreign country): Lacy Springs, Rockingham, Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph K. Summers
14. MOTHER'S MAIDEN NAME: Margaret Virginia Earman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): - - -
16. SOCIAL SECURITY NO: 946-71-0016
17. INFORMANT: Decedent Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism, clinical — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Carcinoma, right kidney, resected — 8 mo.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis, moderately advanced
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/9/ 19 65 to 10/20/ 19 67, that (I) (we) last saw the deceased alive on 10/20/ 19 67, and that death occurred at 3:00 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10/20/67
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-23-67
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
23d. LOCATION (City or Town) (County) (State): WASHINGTON, D.C.
24. FUNERAL DIRECTOR: LEE FUNERAL HOME
ADDRESS: 800 4TH ST.
25a. REC'D BY (Registrar): DATE: OCT 24 1967
SIGNATURE: Charles Judge

BF

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14251 Item #9 Film #6393 10/7/67 ph

CERTIFICATE OF DEATH

14256

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 1926 11th St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mattie — Middle: — Last: Blow
4. DATE OF DEATH: Month: October — Day: 1 — Year: 19 67
5. SEX: F
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/25/04
9. AGE (In years last birthday): 63 (62) yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (County & State, or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Julia Foster
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: unknown
17. INFORMANT: decedent — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral bronchopneumonia (10 days) with superimposed pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) (thrombosis inferior vena cava) — unknown
DUE TO (c) Fracture of the odontoid process with resultant quadriparesis — 10 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Focal encephalomalacia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 5/31/, 1967, to 10/1/, 1967, that I (we) last saw the deceased alive on 10/1/ 1967, and that death occurred at 10:06 PM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 10/1/67
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 7, 1967
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Harmony Memorial
23d. LOCATION (City or Town) (County) (State): Prince Geo. County, Md.
24. FUNERAL DIRECTOR: Datneys Funeral Home — ADDRESS: 3831 Ga. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR: OCT 6 1967
25b. REGISTRAR'S SIGNATURE: O'Donnelan Judge

VR A15 (4) 25M 1/67

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M

14252

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14257

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AFB
c. LENGTH OF STAY IN 1b: 106 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MALCOLM GROW USAF HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ALEXANDRIA
d. STREET ADDRESS: 457 ARGYLE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle MASON Last BOATNER

4. DATE OF DEATH: Month OCTOBER Day 30 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2 Jan 1910
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NA
11. BIRTHPLACE (State or foreign country): NEW ORLEANS, LA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JACOB ALLEN GORMAN
14. MOTHER'S MAIDEN NAME: EDITH PEAKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NA
16. SOCIAL SECURITY NO.: 302-40-8212
17. INFORMANT: HUSBAND Address: SAME AS #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO (b) Bronchitis (Obstructive multifocal) — 5 months
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 17 Jul 1967, to 31 Oct 1967 that (I) (we) last saw the deceased alive on 30 Oct 1967 and that death occurred at 1149 A.M. from the causes and on the date stated above

22a. SIGNATURE: Robert J. Wilkus M.D. — M.D
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 30 Oct 67
22c. PHYSICIAN'S NAME (Type): ROBERT J. WILKUS, CAPT, USAF MC
22d. ADDRESS: Malcolm Grow USAF Hospital Andrews AFB, Wash DC 20331

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-1-67
23c. NAME OF CEMETERY OR CREMATORY: Arl. National Cemetery
23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Early-Whatley Funeral Home — ADDRESS: Alex., Va.
25a. REC'D BY REGISTRAR DATE NOV 2 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coupon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14253 14258

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: D. C. — b. COUNTY: --------
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 906 Aspen Street N. J.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: SAM — Middle: — Last: BORAK
4 DATE OF DEATH: Month: October — Day: 16 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 10, 1895
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed
10b. KIND OF BUSINESS OR INDUSTRY: Merchant
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Saul Barak
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 217-32-2082 A
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4444
DUE TO (b): CARDIAC ARREST DUE TO PONEUMONITIS — INTERVAL BETWEEN ONSET AND DEATH: 4-5 DAYS
DUE TO (c): & ARTERIOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from NOV. 10, 1959, to 15 OCT., 1967, that (I) (we) last saw the deceased alive on 15 OCT. 1967, and that death occurred 12:43 A M, from causes and on the date stated above.

22a. SIGNATURE: Henry R. Wolfe M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-16-1967
22c PHYSICIAN'S NAME (Type): Henry R. Wolfe, M.D.
22d. ADDRESS: 905 Sheridan Street, Chillum Terrace, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10-17-67
23c. NAME OF CEMETERY OR CREMATORY: Beth Sholom Cemetery
23d LOCATION (City or Town) (County) (State): Capitol Heights Md.

24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St., N.W.
25a. REC'D BY REGISTRAR DATE: OCT 20 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14256 Item #8 Film #G39, 10/27/67 ph

CERTIFICATE OF DEATH

14259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: 1923 Bel Haven Drive #201
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: E. — Last: Bowling
4. DATE OF DEATH: Month: Oct. — Day: 18, — Year: 1967
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/25/1900 (1901)
9. AGE (In years lost birthday): 66 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Edward Douglas
14. MOTHER'S MAIDEN NAME: Matilda M. Berry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Zelda S. Clark - 1923 Belle Haven Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction
DUE TO (b): Severe stenosing coronary arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (we) (this hospital) attended the deceased from Oct. 10, 1967, to Oct. 18, 1967, that (we) last saw the deceased alive on Oct. 18, 1967, and that death occurred at 8:50 AM, from causes and on the date stated above.

22a. SIGNATURE: Fidel Quintana M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Fidel Quintana, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-24-67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park
23d. LOCATION (City or Town) (County) (State): Prince George, Maryland
24. FUNERAL DIRECTOR: Rhines Funeral Home — ADDRESS: 3015 12th St. NE
25a. REC'D BY REGISTRAR: DATE OCT 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14255

CERTIFICATE OF DEATH

14260

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Meadows, ~~[illegible]~~ Upper Marlboro
d. STREET ADDRESS: R F D Box 4276
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Isabelle — Middle: Almira — Last: Bradburn ~~[illegible]~~
4 DATE OF DEATH: Month: Oct. — Day: 1 — Year: 19 67
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 24 Sept., 1890
9 AGE (In years lost birthday): 77 YRS — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd Interior Decorator
10b. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12 CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Thomas Beavers
14. MOTHER'S MAIDEN NAME: Annie Augherton
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Eleanor B. Sewell — Address: 723 14th St., N.W. Albuquerque, N.M.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiopulmonary arrest Stroke — INTERVAL BETWEEN ONSET AND DEATH: 4 4 X
DUE TO (b): Cerebral thrombosis — 1 week
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension Atherosclerotic Heart Disease, Anemia
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 9-28, 1967, to 10-1, 1967, that (I) (we) last saw the deceased alive on 9-30, 1967, and that death occurred at 1.00 AM, from causes and on the date stated above

22a SIGNATURE: Oliver B. Bond — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 10-1-67
22c. PHYSICIAN'S NAME (Type): OLIVER B. BOND — Oliver B. Bond, M. D.
22d ADDRESS: 6872 RIVERDALE RD LANHAM MD 20801

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/ 4/67
23c NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d LOCATION (City or Town) (County) (State): Bladensburg Md.
24. FUNERAL DIRECTOR: Ritchie Bros. Upper Marlboro, Md. — ADDRESS
25a REC'D BY REGISTRAR DATE: OCT 4 1967
25b REGISTRAR'S SIGNATURE: Charles Juergen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14261

14256

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 6816 Redtop Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecelia — Middle: Agnes — Last: Brady

4. DATE OF DEATH: Month: 10 — Day: 26 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 18 Oct. 1920
9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: THE HECHT Co.
11. BIRTHPLACE (State or foreign country): LONG ISLAND NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN O'MALLEY
14. MOTHER'S MAIDEN NAME: DELIA McDONOUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT: FRANK M. O'MALLEY — Address: DALTON, PENNA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Liver failure — INTERVAL BETWEEN ONSET AND DEATH: over 4 yrs.
5810
DUE TO (b) Cirrhosis of liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
Address (Street, city, town, or county)
22. DATE SIGNED: 10-27-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Oct. 31, 1967
23c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS CEMETERY
23d. LOCATION (City or Town) (County) (State): QUEENS COUNTY, NEW YORK

24. FUNERAL DIRECTOR: W.W. CHAMBERS Co — ADDRESS: RIVERDALE, MD
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14262

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c LENGTH OF STAY IN 1b: 48 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Prince George's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Hills
d STREET ADDRESS: 4202 72nd. Ave.
e IS RESIDENCE ON A FARM? YES [ ] NO [x]

3 NAME OF DECEASED (Type or print): First: Albert — Middle: H — Last: Braund
4 DATE OF DEATH: Month: 10 — Day: 27 — Year: 1967
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED [x] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: 3-18-1905
9 AGE (In years last birthday): 62 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHEET METAL WORKER
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): DISTRICT of COLUMBIA
12 CITIZEN OF WHAT COUNTRY? U.S
13 FATHER'S NAME: UNKNOWN BRAUND
14 MOTHER'S MAIDEN NAME: UNKNOWN
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
16 SOCIAL SECURITY NO: 578037194
17 INFORMANT: MRS. BERTHA M. BRAUND, Address: SAME AS #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO 3rd. degree burns of both legs (20% of body) — 48 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES [ ] NO [x]

20a EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [x] CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.): Gasoline spilled on pants which caught fire.
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 1:00pm p.m. 9-10- 1967
20d INJURY OCCURRED While at work [ ] Not While at work [x]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f (City or town) (County) (State): same as #2

21 I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [x], Inquiry [x], and in my opinion death resulted from Natural causes [ ], Accident [x], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [x]
Address (Street, city, town, or county)
22. DATE SIGNED: 10-27-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: Oct 30, 1967
23c NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM
23d LOCATION (City or Town) (County) (State): COLMAR MANOR, MARYLAND
24 FUNERAL DIRECTOR: W.W. CHAMBERS Co.
ADDRESS: RIVERDALE, MD.
25a REC'D BY REGISTRAR DATE: NOV 1 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5 in 5 days be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14259

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14263

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural (Clinton)
c. LENGTH OF STAY IN 1b: Driving Thru
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Rt. 5 nr Surrats Rd.

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Mt. District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 660 Independence Ave., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: George — Middle: Fred — Last: Bremier

4 DATE OF DEATH: Month: 10 — Day: 14 — Year: 19 67

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3 Sept 1932
9 AGE (In years last birthday): 35 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mathematician
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy Yard
11 BIRTHPLACE (State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: George L. Bremier
14 MOTHER'S MAIDEN NAME: Margaret Krosenic

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT: Mary Bremier — Address: Same as #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Burns 100% of body surface — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver of car involved in collision
20c TIME OF INJURY: Hour a.m. 8:20pm — Month, Day, Year: 8 14 19 67
20d INJURY OCCURRED: While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): St. Rt. 5
20f (City or town): Clinton — (County): P.G. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, MD
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):
22. DATE SIGNED: 10-15067

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/17/67
23c NAME OF CEMETERY OR CREMATORY: Washington Natl. Cem.
23d LOCATION (City or Town): Suitland — (County): Pr.Geo. — (State): Md.

24 FUNERAL DIRECTOR: J. Wm. Lees Sons, 300 4th St., NE, Wash. DC — ADDRESS
25a RECD BY REGISTRAR: DATE OCT 18 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 HOURS after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14253 — 15753

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN Ib: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: General Delivery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Bryce
4. DATE OF DEATH: Month: Oct. — Day: 26, — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 25, 1967
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours 23 / Min 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): Prince George's, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Wells Colbert
14. MOTHER'S MAIDEN NAME: Barbara Ann Bryce
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO (b): Atelectasis of lungs. bilateral
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 25, 1967, to Oct. 26, 1967, that (I) (we) last saw the deceased alive on Oct. 26, 1967, and that death occurred at 4:15 PM, from causes and on the date stated above

22a. SIGNATURE: [signature] — M.D. ☐ ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10/27/67
22c. PHYSICIAN'S NAME (Type): Hugh Clark, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): William A. Parker
23b. DATE THEREOF: 11-11-67.
23c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital
23d. LOCATION (City or Town) (County) (State): Cheverly, Maryland
24. FUNERAL DIRECTOR: William A. Parker, Cheverly, MD.
ADDRESS
25a. RECEIVED BY REGISTRAR — DATE: NOV 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18, 21 film 398

3- -c at 14260

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14264

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
d. STREET ADDRESS: 6009 Allentown Road
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Evelyn; Middle: Elizabeth; Last: Buckler

4. DATE OF DEATH: Month: 10; Day: 26; Year: 19 67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 4-4-14
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter J. Ogden
14. MOTHER'S MAIDEN NAME: Alice M. Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Helen V. McDonald (Sister) Address: Same as #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intoxication n-ethyl alcohol
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale, Maryland
Address (Street, city, town, or county)
22. DATE SIGNED: 10-28-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 30-1967
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
23d. LOCATION (City or Town) (County) (State): Clinton, Maryland

24. FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Simmons Bros. 1601- Good Hope Rd. SE. Wash., DC
25a. REC'D BY REGISTRAR DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14261

CERTIFICATE OF DEATH

14265

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN (b): 3mos.,24days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital, Glenn Dale, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5021 Ayers Pl., S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice Middle: K. Last: Bundy
4. DATE OF DEATH: Month: 10 Day: 27 Year: 19 67
5. SEX: F
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/13/1898
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ? retired
10b. KIND OF BUSINESS OR INDUSTRY: ??
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charlie Smith
14. MOTHER'S MAIDEN NAME: Frances Parker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 577-26-2268
17. INFORMANT: Decedent Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS
DUE TO
(b) CHRONIC RENAL FAILURE — MANY YEARS
DUE TO
(c) ARTERIOLAR NEPHRO-SCLEROSIS — MANY YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
HYPERTENSIVE CARDIOVASCULAR DISEASE (2) ARTERIO-SCLEROTIC HEART DIS
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from 7/31, 19 67, to 10/27/, 1967, that (☒) (we) last saw the deceased alive on 10/27/ 19 67, and that death occurred at 1:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D. ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10/27/67
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify):
23b. DATE THEREOF: 11-1-67
23c. NAME OF CEMETERY OR CREMATORY: Church Cemetery
23d. LOCATION (City or Town) (County) (State): Culpper VA.

24. FUNERAL DIRECTOR: John F. Grafton & Son
ADDRESS: 3435 14th St. N.W.
25a. REC'D BY REGISTRAR DATE: OCT 31 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT.

14262

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14266

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chillum
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5507 Sargent Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chillum
d. STREET ADDRESS: 5507 Sargent Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: M — Last: Burgess
4. DATE OF DEATH: Month: 10 — Day: 30 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-26-1886
9. AGE (In years last birthday): 81 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Hornback
14. MOTHER'S MAIDEN NAME: Amelia Veidt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Lucile Sanchez — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus - over 5 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 10-30-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Washington D. C
24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14267

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5393 Quincy St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: Earl — Last: Canterbury
4. DATE OF DEATH: Month: 10 — Day: 22 — Year: 19 67
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 21 April 1923
9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: construction
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Benjamin Canterbury
14. MOTHER'S MAIDEN NAME: Alla Alliff
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Edna L Canterbury — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
4200
DUE TO (b): Arteriosclerotic heart disease — over 1 yr.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale, Md.
Address (Street, city, town, or county)
22. DATE SIGNED: 10-22-67

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct.26,1967
23c. NAME OF CEMETERY OR CREMATORY: Huse Memorial Cemetery
23d. LOCATION (City or Town): Fayetteville — (County) — (State): W.Va.

24. FUNERAL DIRECTOR: F. Gasch & Sons, Hyattsville, Md. — ADDRESS
25a. REC'D BY REGISTRAR — DATE: OCT 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14265 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14268

1 PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN Hospital: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highland Park
d. STREET ADDRESS: 1102 69th. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Jerry Middle Jeremiah Franklin Last Chapman

4 DATE OF DEATH: Month 10 Day 25 Year 19 67

5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 17 July 1909
9 AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerry J. Chapman
14. MOTHER'S MAIDEN NAME: Mary Chiltons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO:
17. INFORMANT: Myrtle Chapman Address: Same as 2D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO Thrombophlebitis of left leg — over 10 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary emphysema - over 10 months
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 10-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-28-67
23c. NAME OF CEMETERY OR CREMATORY: Harmony
23d. LOCATION (City or Town) (County) (State): Highland Park Md

24. FUNERAL DIRECTOR: H. S. Washington & Sons
ADDRESS: 4925 Dennis Ave NE
25a. REC'D BY REGISTRAR DATE OCT 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14269

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Hill
d. STREET ADDRESS: 6310 Dudley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: William — Middle: J. — Last: Claspell Sr.

4 DATE OF DEATH: Month: 10 — Day: 29 — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8 DATE OF BIRTH: 1 June 1894
9. AGE (In years last birthday): 73 Yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operating Engr.
10b KIND OF BUSINESS OR INDUSTRY: Arundel Supply Corp.
11 BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: William J. Claspell
14 MOTHER'S MAIDEN NAME: ~~XXXXXXXXXXX~~ Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 578 01 4112
17 INFORMANT: Florence E. Claspell — Address: Same as Item 12

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO Arteriosclerotic heart disease — over 2 wks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PEREORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county)
22. DATE SIGNED: 10-30-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct. 31-1967
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Suitland, Md.

24 FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Simmons Bros. 1601-Good Hope Rd SE Wash DC
25a REC'D BY REGISTRAR DATE: NOV 1 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14268

CERTIFICATE OF DEATH

14270

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural (Glenn Dale)
c. LENGTH OF STAY IN 1b: 5 mo. 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1616 17th Place, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William Thomas — Middle: — Last: Clayton

4. DATE OF DEATH: Month: Oct. — Day: 21 — Year: 19 67

5 SEX: Male
6. COLOR OR RACE: Caucasian
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: March 8,1891
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown DISPATCHER
10b. KIND OF BUSINESS OR INDUSTRY: CONCRETE Co
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: John Clayton
14 MOTHER'S MAIDEN NAME: M. Frances Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): -
16. SOCIAL SECURITY NO.: 577-10-5611
17. INFORMANT: Hadley Hospital — Address: Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b) cerebrovascular accident with right hemiparesis — years
DUE TO
(c) hypertensive and arteriosclerotic cardiovascular disease — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary emphysema and fibrosis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/10, 19 67, to 10/21, 19 67, that (I) (we) last saw the deceased alive on 10/21 1967, and that death occurred at 8:00 A.M. from causes and on the date stated above.

22a SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: Oct. 21, 1967
22c PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d ADDRESS: GlennDale Hospital, Glenn Dale, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT. 23, 1967
23c NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEM
23d LOCATION (City or Town) (County) (State): BLADENSBURG MD.

24. FUNERAL DIRECTOR: W.W. Chambers Co. — ADDRESS: Riverdale Md 5801 Cleveland Ave
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

Items 18,20,21 film 397 MARYLAND STATE DEPARTMENT OF HEALTH
2-15-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14271

14267

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wooded area off Bell Station Road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: Bell Station Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16

3 NAME OF DECEASED (Type or print): First: Carrie — Middle: Elizabeth — Last: Conwell
4 DATE OF DEATH: Month: 10 — Day: 30 — Year: 19 67
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4-9-1936
9 AGE (In years last birthday): 31 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (State or foreign country): Glenn Dale, Md.
12 CITIZEN OF WHAT COUNTRY? U S A
13 FATHER'S NAME: Cleveland Beall
14 MOTHER'S MAIDEN NAME: Vida Harvey
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):
16 SOCIAL SECURITY NO: 220 32 5348
17 INFORMANT: O E Conwell Jr — Address: Lanham, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
7328
IMMEDIATE CAUSE (a): Intoxication Doriden — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Exposure to cold — 3 days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): Froze while in woods after overdose of Doriden
20c TIME OF INJURY: Month, Day, Year: 10-26 1967 — Hour a.m. p.m.
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Woods
20f (City or town): Lanham — (County): PG — (State): Md

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):
22. DATE SIGNED: 10-31-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Nov 3, 1967
23c NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery
23d LOCATION (City or Town): Colmar Manor — (County): Pro Georges — (State): Md.
24 FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR: DATE NOV 2 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

M

14268

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14272

1 PLACE OF DEATH
a COUNTY: Prince George's — Md. MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Prince George's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
d STREET ADDRESS: 33 Maryland Avenue
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mary Middle: Dorothy Last: Corker
4 DATE OF DEATH: Month: 10 Day: 1 Year: 1967
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 31 Jan. 1913
9 AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b KIND OF BUSINESS OR INDUSTRY: US Government
11 BIRTHPLACE (State or foreign country): South Carolina
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Edward Boniface
14 MOTHER'S MAIDEN NAME: Margaret Madden
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: Joan Komatsoulis Address: Upper Marlboro 11002 Phillip Dr. Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Hypertensive arteriosclerotic heart disease — over 1 year
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 10-2-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/4/67
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Suitland, Prince Georges, Md
24 FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home ADDRESS: 4308 Suitland Road, Suitland, Maryland
25a REC'D BY REGISTRAR: OCT 6 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1273

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: five days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6118 62nd Place
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: Homer — Middle: Warren — Last: Corso
4 DATE OF DEATH: Month: 10 — Day: 27 — Year: 19 67
5. SEX: male
6 COLOR OR RACE: white
7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: 4-26-18
9 AGE (In years last birthday): 49 YRS — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired claim examiner
10b. KIND OF BUSINESS OR INDUSTRY: U S Government
11 BIRTHPLACE (State or foreign country): Washington D. C.
12 CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Andrew Corso
14 MOTHER'S MAIDEN NAME: Laura M Mattei
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W W II
16 SOCIAL SECURITY NO: 221 07 8413
17 INFORMANT: Dorothy Corso — Address: Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral infarction
DUE TO
(b) Cerebral embolus
DUE TO
(c) Mural thrombus of left ventricle

9708

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): overdose of Doriden

19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [X] CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): took overdose of Doriden at home
20c TIME OF INJURY Month, Day, Year: Hour 8:00pm a.m. p.m. 10-22 19 67
20d INJURY OCCURRED While at work [ ] Not While at work [X]
20e PLACE OF INJURY (Home, farm factory, street, office bldg, etc.): home
20f. (City or town): Riverdale — (County): P.G. — (State): Md.

21 I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] and in my opinion death resulted from Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland — Address (Street, city, town, or county)
22. DATE SIGNED: 10-28-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 30, 1967
23c NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d LOCATION (City or Town): Colmar Manor — (County): Pro Geo — (State): Md.
24 FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 31 1967
25b REGISTRAR'S SIGNATURE: [illegible]

14270

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AFB
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MALCOLM GROW USAF HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRADBURY HEIGHTS
d. STREET ADDRESS: 5110 S STREET S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MAURIECE — Middle: EUGENE — Last: COX
4. DATE OF DEATH: Month: OCTOBER — Day: 27 — Year: 19 67
5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 26 Nov 30
9. AGE (In years last birthday): 36 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USAF
10b. KIND OF BUSINESS OR INDUSTRY: USAF
11. BIRTHPLACE (County & State, or foreign country): RED STAR, W. VA.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOSEPH ALEXAJDER COX
14. MOTHER'S MAIDEN NAME: NELLIE FAY GRIMETT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 236-44-4586
17. INFORMANT: WIFE — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO
(b): Myocardial Infarction
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 26 Oct, 1967, to 27 Oct, 19 67 that (I)(we) last saw the deceased alive on 27 Oct 67 19___, and that death occurred at 12:03 AM, from causes and on the date stated above.

22a. SIGNATURE: Louis G. Martin, M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 27 Oct 67
22c. PHYSICIAN'S NAME (Type): LOUIS G. MARTIN, CAPT, USAF, MC
22d. ADDRESS: Malcolm Grow USAF Hospital, Andrews AFB, Wash DC 20331

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-31-67
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Arlington, Va.

24. FUNERAL DIRECTOR: Wm Taylor — ADDRESS: Falls Church Funeral Home, Falls Church, Va.
25a. RECD BY REGISTRAR DATE: OCT 31 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jenkins

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14271

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14275

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edmonston 16
d. STREET ADDRESS: 4906 Taylor Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: F. — Last: Culbert

4. DATE OF DEATH: Month: 10 — Day: 20 — Year: 19 67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-2-16
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BEAUTICIAN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): KENTUCKY
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM H. LARGE
14. MOTHER'S MAIDEN NAME: MARY MAUPIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 077-05-8565
17. INFORMANT: BERNICE SANTOS, Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
170X
IMMEDIATE CAUSE (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: over 2 mo.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of breast
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland — Address (Street, city, town, or county)

22. DATE SIGNED: 10-21-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Oct. 23, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. OLIVET CEM
23d. LOCATION (City or Town) (County) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR: W. W. CHAMBERS Co. — ADDRESS: RIVERDALE, MD
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

14272

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14276

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 7614 Romney Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Irene — Middle: Mae — Last: Cummings

4 DATE OF DEATH: Month: 10 — Day: 14 — Year: 19 67

5 SEX: F

6 COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 15 Dec., 1906

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: own home

11 BIRTHPLACE (State or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: Robert Jackson

14. MOTHER'S MAIDEN NAME: Mary Halderman

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Leroy E Cummings — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
(b): Arteriosclerotic heart disease — Unknown
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus-over 15 yrs.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale
Address (Street, city, town, or county):

22. DATE SIGNED: 10-14-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Oct 18, 1967

23c NAME OF CEMETERY OR CREMATORY: United Cemetery

23d LOCATION (City or Town) (County) (State): Pittsburg — Pa

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.

25a REC'D BY REGISTRAR DATE: OCT 16 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5-67) 6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14273 — 14277

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN Hospital: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 116 69th. Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [x]

3. NAME OF DECEASED (Type or print): First: James — Middle: Elmer — Last: Darby
4. DATE OF DEATH: Month: 10 — Day: 5 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [x] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 4 Oct. 1924
9. AGE (In years last birthday): 43 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Construction laborer
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): West Va
12. CITIZEN OF WHAT COUNTRY? U S A.
13. FATHER'S NAME: Spence Darby
14. MOTHER'S MAIDEN NAME: Myrtle L Odell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Erma Darby — Address: 4000 36st Mt Rainier, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laceration of brain — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO: Trauma - struck by train.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a):
19. WAS AUTOPSY PERFORMED? YES [ ] NO [x]

20a. EXTERNAL CAUSE WAS PRIMARY [x] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Pedestrian struck by train
20c. TIME OF INJURY: Hour a.m./p.m. 3:00pm — Month, Day, Year: 9-24- 19 67
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.): B&O Railroad tracks, 200 ft. north of Decatur St., Hyattsville, Md. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [x], Inquiry [x], and in my opinion death resulted from: Natural causes [ ], Accident [x], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [x]
22. DATE SIGNED: 10-5-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 9, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery
23d. LOCATION (City or Town): Colmar Manor Pro Geo — (County) — (State): Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR: DATE OCT 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Yingen

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14274 Item 3 Film 6393 3/12/68 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14278

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Andrew's Air Force Base Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Morningside
d. STREET ADDRESS: 504 Maple Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Swannie Annie; Middle: M; Last: Darne

4 DATE OF DEATH: Month: 10; Day: 24; Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 15 May 1911
9 AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): North Carolina
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: ? Dawson
14 MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT: Doris Tedrow — Address: Same As # 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
33/X
IMMEDIATE CAUSE (a) Cerebro vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Hypertensive vascular disease — over 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22 DATE SIGNED: 10-25-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/27/67
23c NAME OF CEMETERY OR CREMATORY: Great Falls Cemetery
23d LOCATION (City or Town) (County) (State): Herdon, Virginia

24. FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home
ADDRESS: 4308 Suitland Road, Suitland, Maryland
25a REC'D BY REGISTRAR: DATE OCT 30 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

Item 18 Film 395 11-20-

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14279

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital, Glenn Dale, Md.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 3220 Conn. Ave., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle D. Last Darr
4. DATE OF DEATH: Month 10 Day 29 Year 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 6/28/1908
9. AGE (In years last birthday): 59 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Stenographer
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harry F. Dill
14. MOTHER'S MAIDEN NAME: Elizabeth Schrone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-14-0874
17. INFORMANT: Decedent — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumococcal meningitis — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO
(b)
DUE TO
(c) Pneumococcal pneumonia, left upper lobe — 17 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/19/, 19 67, to 10/29/, 19 67, that (I) (we) last saw the deceased alive on 10/29/ 1967, and that death occurred at 11:30 AM, from causes and on the date stated above

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10/29/67
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/3/67
23c. NAME OF CEMETERY OR CREMATORY: Weiton Cemetery
23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR: Harley & Lavenaugh, Inc. ADDRESS: Frederick & Baltimore Mrs. Lady Md.
25a. REC'D BY REGISTRAR DATE NOV 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (1)
25M 1/67

Unit II Chronic Alcoholism — 1st d
11/10/47

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15278 1-1280

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Forest Hights
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 11--Delaware Dr., S. E.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Forest Heights
d. STREET ADDRESS: 11--Delaware Dr., SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: G. Last: DISNEY
4. DATE OF DEATH: Month: Oct. Day: 8th Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 25-1897
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & Laundry Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Price
14. MOTHER'S MAIDEN NAME: Almira Turnhaugh
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579 05 6516
17. INFORMANT: Wm. J. Disney Jr. Address: Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure
DUE TO (b): Rheumatic fever / Mitral stenosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 30 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 4. 24, 1967, to 10. 3, 1967, that (I) (we) last saw the deceased alive on 10. 3. 1967 19____, and that death occurred at 6 A M, from the causes and on the date stated above.

22a. SIGNATURE: Dr. Etienne Szollosi M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Oct. 8-1967
22c. PHYSICIAN'S NAME (Type): Dr. Etienne Szollosi
22d. ADDRESS: #2 Parkway Dr., SE Forest Hgts, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 11-67
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Bladensburg, Md.

24. FUNERAL DIRECTOR: Simmons Bro. 1661-Good Hope Rd SE Wash DC
25a. REC'D BY REGISTRAR — DATE: OCT 11 1967
25b. REGISTRAR'S SIGNATURE: James Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14273 14281

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville

c. LENGTH OF STAY IN 1b 10 Years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Mannor, 4922 LaSalle Road

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D.C. b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.

d STREET ADDRESS 508 Crittenden St., N.W.

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Rosina Middle Irene Last DUGAN

4. DATE OF DEATH Month Oct Day 13 Year 19 67

5. SEX Female

6. COLOR OR RACE White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Jan 15, 1876

9 AGE (In years last birthday) 91 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Homemaker

11. BIRTHPLACE (State or foreign country) Brooklyn, New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel Caffrey

14 MOTHER'S MAIDEN NAME Jenny O'Brien

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17 INFORMANT Address Sister M. Dominic - Carroll Mannor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene Right leg

DUE TO (b) Generalized arteriosclerosis

DUE TO (c) and Diabetes Mellitus

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH 72 hours 8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 1959, 19__, to 1967, 19__, that (I) ~~(we)~~ last saw the deceased alive on 10/12/67 19__, and that death occurred at 12:45 P.M. from the causes and on the date stated above.

22a SIGNATURE William F. Simpson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED 10/13/67

22c. PHYSICIAN'S NAME (Type) WILLIAM F. SIMPSON

22d ADDRESS 6216 NH Ave NE - Wash. DC.

23a BURIAL CREMATION REMOVAL (Specify) Burial

23b DATE THEREOF 10/16/67

23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery

23d LOCATION (City town, or county) (State) Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 5130 Wisconsin Ave., N.W. Joseph Gawler's Sons, Washington, D.C. 20016

25a REC'D BY REGISTRAR DATE OCT 18 1967

25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

74278 — 14283

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 327 Montgomery St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle W. — Last Elliott
4. DATE OF DEATH: Month Oct. — Day 18, — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/6/95
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer
10b. KIND OF BUSINESS OR INDUSTRY: Bldg trades
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Elliott
14. MOTHER'S MAIDEN NAME: Margaret Ritter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charlotte E. Stone 4308 Sandy Spring Rd. Burtonsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO
(b): Arteriosclerosis C.V. Disease
DUE TO
(c): Pulmonary Emphysema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/5/67, 19__ to 10/18/67, that (I) (we) last saw the deceased alive on 10/67 1967, and that death occurred at 3:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: Paul H. Whyte M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/18/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 23, 1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl Cemetery
23d. LOCATION (City or Town) (County) (State): Arlington, Va

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 550 Washington Blvd Laurel, Maryland
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14279

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-4284

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and [illegible] the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. [illegible] 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

99

1. PLACE OF DEATH a. COUNTY: Prince George's — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly c. LENGTH OF STAY IN 1b: DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland — b. COUNTY: Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood d. STREET ADDRESS: 4409 38th. Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Frank — Middle: Elmer — Last: Embrey	4. DATE OF DEATH: Month: 10 — Day: 4 — Year: 1967
5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 20 Jan. 1904 9. AGE (In years lost birthday): 63 yrs If UNDER 1 YEAR: Months: — Days: — If UNDER 24 HRS: Hours: — Min: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Lieut. U.S. 10b. KIND OF BUSINESS OR INDUSTRY: Pentagon Bldg	11. BIRTHPLACE (State or foreign country): WASHINGTON D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: MARSHALL EMBREY	14. MOTHER'S MAIDEN NAME: MARY GARRETT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 1922-1925 16. SOCIAL SECURITY NO: 578149534 17. INFORMANT: ELSIE MAY EMBREY, Address: Same AS #2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — over 3 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes - over 5 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 10-5-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: Oct. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM.	23d. LOCATION (City or Town) (County) (State): SUITLAND, MARYLAND
24. FUNERAL DIRECTOR: W.W. CHAMBERS, Co.	ADDRESS: RIVERDALE, MD	25a. REC'D BY REGISTRAR DATE: OCT 10 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

14280

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14295

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 4818 Eastern Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Virginia — Middle: S. — Last: Falls
4. DATE OF DEATH: Month: Oct. — Day: 10, — Year: 19 67
5 SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
8 DATE OF BIRTH: 2/15/~~19~~ 96
9 AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): West Virginia
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Scott
14. MOTHER'S MAIDEN NAME: Velaria O. Lawson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Velaria S. Kittredge, Same As # 2 — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Cell Carcinoma of left kidney (Hypernephroma) — INTERVAL BETWEEN ONSET AND DEATH: 120X
DUE TO
(b) Arteriosclerotic Cardio Vascular Disease — 2 years
DUE TO
(c) Essential Hypertension — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES XX NO ☐
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from May, 1967, to Oct. 10, 1967, that (I) (~~we~~) last saw the deceased alive on Oct. 10, 1967, and that death occurred at 7:50 PM, from causes and on the date stated above.

22a SIGNATURE: [signature] M.D. ATTENDING PHYS XX MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: Oct. 10, 1967
22c. PHYSICIAN'S NAME (Type): Ohannes Sahakyan, M.D.
22d. ADDRESS: 6001 Landover Rd. Cheverly, Md. 20785

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/15/67
23c NAME OF CEMETERY OR CREMATORY: Greenbriar Cemetery
23d LOCATION (City or Town) (County) (State): Hinton West Virginia
24 FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home — ADDRESS: 4308 Suitland Rd, Suitland, Md. — Wilhelm
25a REC'D BY REG. STRAR — DATE: OCT 16 1967
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
25M 1/67

14 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14281 **CERTIFICATE OF DEATH** 14286

1. PLACE OF DEATH a. COUNTY: Pr Geo — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVERDALE
c. LENGTH OF STAY IN 1b: 101 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): LELAND MEMORIAL Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BELTSVILLE
d. STREET ADDRESS: 4407 FRANKLIN Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HAZEL Middle E Last FARRELL
4. DATE OF DEATH: Month Oct Day 29 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-8-94
9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): WASH DC
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: J Snider
14. MOTHER'S MAIDEN NAME: MAGGIE Cockerill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-01-2650
17. INFORMANT: Hosp Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a): Cor Pulmonale Asphyxia c Uremia
DUE TO (b): Hypertensive Cerebral Vascular dis c Senility
DUE TO (c): Advanced Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o'm. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/16, 19 67, to Oct 67, 19__, that (I) (~~we~~) last saw the deceased alive on 10/28 1967, and that death occurred at 1:30 PM, from causes and on the date stated above.

22a. SIGNATURE: W L Etienne M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/29/67
22c. PHYSICIAN'S NAME (Type): W.L. ETIENNE
22d. ADDRESS: College Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Suitland Pr Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14282

CERTIFICATE OF DEATH

14287

1 PLACE OF DEATH
a. COUNTY: Prince Geo. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
c. LENGTH OF STAY IN 1b: 2 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Magnolia Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr.Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chillum
d. STREET ADDRESS: 1325 - Nicholson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene Middle: E. Last: Finley
4. DATE OF DEATH: Month: Oct. Day: 18 Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/17/1890
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Stenographer
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt.
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Maher
14. MOTHER'S MAIDEN NAME: Teresa Tulley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 150-34-6479-A
17. INFORMANT: Chas.T. Finley (above address) (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO
(b): Cancer of bladder — 4 months
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): pernicious anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1965, 19 to Oct 18, 19 67 that (I) (we) last saw the deceased alive on Oct 18 1967, and that death occurred at 8:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Oct 18, 1967
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/21/67
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.
24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc. ADDRESS: Mt.Rainier Maryland
25a. REC'D BY REGISTRAR DATE: OCT 23 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

9—1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14283

CERTIFICATE OF DEATH

14283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 600 Addison Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Carl — Middle: M. — Last: Fischer
4. DATE OF DEATH: Month: Oct. — Day: 20, — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/23/08
9. AGE (in years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millwright
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Carl M. Fisher
14. MOTHER'S MAIDEN NAME: Catherine Preston
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Frances M. Fischer, wife — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO
(b) Bronchogenic Carcinoma, left upper lobe
DUE TO
(c)
1621
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(attended)~~ attended the deceased from July 1, 1967, to Oct. 20, 1967, that (I) ~~(was)~~ last saw the deceased alive on Oct. 20, 1967, and that death occurred at 8:30 AM, from causes and on the date stated above.

22a. SIGNATURE: William Brainin M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Oct. 20, 1967
22c. PHYSICIAN'S NAME (Type): William Brainin, M. D.
22d. ADDRESS: 6124 Central Ave. Capital Hghts. Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/24/67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Princes Georges, Maryland

24. FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home — ADDRESS: 4308 Suitland Road, Suitland, Maryland
25a. REC'D BY REGISTRAR: DATE OCT 25 1967
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
25M 1/67

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FOR STATE HEALTH DEPT.

M

14284

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14289

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): West Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 2709 Nicholson Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): West Hyattsville
d. STREET ADDRESS: 2709 Nicholson Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Rose — Middle: Lillian — Last: Fleishman

4. DATE OF DEATH: Month: 10 — Day: 2 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 9-11-1917

9. AGE (In years last birthday): 50 yrs — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Typist

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Morris Fleishman

14. MOTHER'S MAIDEN NAME: Frieda Finn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO:

17. INFORMANT: Brother — Address: S.S. Jacob Fleishman 9713 Saxony Rd. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Rupture of myocardium	minutes
DUE TO (b)	Myocardial infarction	days
DUE TO (c)	From coronary occlusion left coronary artery	unknown
	From coronary atherosclerotic heart disease	

T+U1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town or county): Riverdale, Md.

22. DATE SIGNED: 10-3-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-4-67

23c. NAME OF CEMETERY OR CREMATORY: Ohev Sholom-Talmud Torah Cem.

23d. LOCATION (City or Town) (County) (State): Washington DC

24. FUNERAL DIRECTOR: Bernard Danzansky and Sons — ADDRESS: Washington, DC

25a. RECORDED BY REGISTRAR: DATE: OCT 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

1

14285

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

142290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood 16
d. STREET ADDRESS: 4512 Rhode Island Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Ernest — Middle — Last Foster
4. DATE OF DEATH: Month Oct. Day 8, Year 1967
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/4/04
9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): D.C
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Foster
14. MOTHER'S MAIDEN NAME: Susie Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Blanche Newman — Address: 4404 Banks Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. — INTERVAL BETWEEN ONSET AND DEATH
150 X
IMMEDIATE CAUSE (a): Esophageal carcinoma
DUE TO
(b):
DUE TO
(c): Sclerodermia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old Tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 26, 1967, to Oct. 8, 1967, that (I) (we) last saw the deceased alive on Oct. 8, 1967, and that death occurred at 3:15 PM, from causes and on the date stated above.

22a. SIGNATURE: Fidel J. Quintana M.D. — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Fidel J. Quintana, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 10-14-67
23c. NAME OF CEMETERY OR CREMATORY: Harmony
23d. LOCATION (City or Town) (County) (State): Highland Park Md

24. FUNERAL DIRECTOR: H.S. Washington & Son — ADDRESS: 4905 Deane Ave
25a. REC'D BY REGISTRAR — DATE: OCT 16 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. S may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14286

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14291

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Hill
d. STREET ADDRESS: 6707 Palmer Road
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Harvey — Middle: — Last: Fox
4. DATE OF DEATH: Month: 10 — Day: 23 — Year: 19 67
5. SEX: male
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 10-23-1881
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Aarron Fox
14. MOTHER'S MAIDEN NAME: Rebbeca Fox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 217 30 0266
17. INFORMANT: Carrie F. Hill — Address: 624 Hamilton St.N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Arteriosclerotic Heart Disease — over 1 yr.
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland — Address (Street, city, town, or county)
22. DATE SIGNED: 10-23-67

23a. BURIAL, CREMATION, REMOVAL (Specify):
23b. DATE THEREOF: 10/27/67
23c. NAME OF CEMETERY OR CREMATORY: St. Paul Methodist
23d. LOCATION (City or Town) (County) (State): Oxon Hill Md.

24. FUNERAL DIRECTOR: ROBERT S. MASON FUNERAL HOME, INC. — ADDRESS: 2500 NICHOLS AVENUE, S. E.
25a. REC'D BY REGISTRAR: DATE: OCT 31 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

14287

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14292

1 PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c LENGTH OF STAY IN 1b: 50 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: Maryland
b COUNTY: Prince George's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d STREET ADDRESS: 7425 Euclid Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Jennifer Middle Lynn Last Fyfe
4 DATE OF DEATH: Month 10 Day 26 Year 19 67
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4-19-1966
9 AGE (In years last birthday): 1 yrs
IF UNDER 1 YEAR: Months 6 Days
IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY? U S A
13 FATHER'S NAME: Raymond Fyfe
14 MOTHER'S MAIDEN NAME: Gloria Harris
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: ----
17. INFORMANT: Raymond Fyfe Address: Landover, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
3400
IMMEDIATE CAUSE (a) Meningites (hemophilus influenza)
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, inspection ☒, inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D.
Address (Street, city, town or county): Riverdale, Md.
22 DATE SIGNED: 10-26-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 27, 1967
23c NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery
23d LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR: F. Gasch's Sons
ADDRESS: Hyattsville, Md.
25a RECEIVED BY REGISTRAR DATE: OCT 30 1967
25b REGISTRAR'S SIGNATURE: Clinton Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MEC
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

14288

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14293

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 6 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 407 Montrose Avenue

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 407 Montrose Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Claire — Middle: V — Last: Galloway
4. DATE OF DEATH: Month: 10 — Day: 16 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1 March 1925
9. AGE (In years last birthday): 42 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Advertising
11. BIRTHPLACE (State or foreign country): Rosedale, Kansas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Virgil Galloway
14. MOTHER'S MAIDEN NAME: Margurite Olive Jewell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): WW 11
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margurite Hill — Address: 791 Forest St., Denver, Colo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-17-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: Oct 19 1967
23c. NAME OF CEMETERY OR CREMATORY: Dist Funeral
23d. LOCATION (City or Town): Silver Hill (County): PG (State): Md

24. FUNERAL DIRECTOR: [illegible]
ADDRESS: [illegible]
25a. REC'D BY REGISTRAR DATE: OCT 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

14288

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14294

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: PRINCE Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANHAM
c. LENGTH OF STAY IN 1b: 3 yrs. 3 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MAGNOLIA GARDENS Nurse Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANHAM
d. STREET ADDRESS: 7318 Powhatan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: CLARA Middle: M Last: GANT

4 DATE OF DEATH: Month: October Day: 7 Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8 DATE OF BIRTH: 9 Jan 1879
9 AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): INDIANA
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Tobias Nolan
14 MOTHER'S MAIDEN NAME: Elizabeth Day

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 212-58-8022
17 INFORMANT: Mr. Robt. Keller — Address: 4 Geo Baker Rd Davidsonville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: Gms
DUE TO (b): PNEUMONIA — 24 hrs.
DUE TO (c): ARTERIOSCLEROTIC HEART DISEASE — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4200

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July, 1963 to Oct, 1967, that (I) (~~we~~) last saw the deceased alive on Oct 6 1967, and that death occurred at 4:4 A.M., from causes and on the date stated above.

22a SIGNATURE: Thomas G Maloney M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: Oct 7, 1967
22c PHYSICIAN'S NAME (Type): Dr. THOMAS G MALONEY
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 11 1967
23c NAME OF CEMETERY OR CREMATORY: Calvary Cem
23d LOCATION (City or Town) (County) (State): Indianapolis Ind

24. FUNERAL DIRECTOR: W. W. Chambers Co.
ADDRESS: Riverdale, Md.
25a RECD BY REGISTRAR DATE: OCT 11 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14290

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14295

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 3531 Madison Place
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: Paul — Last: Gelardo
4. DATE OF DEATH: Month: 10 — Day: 5 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: 12-17-1918
9. AGE (In years last birthday): 48 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemist
10b. KIND OF BUSINESS OR INDUSTRY: U S Government
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Anthony Macellaro
14. MOTHER'S MAIDEN NAME: Camille Macellaro
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): W W 11
16. SOCIAL SECURITY NO: 088 16 8991
17. INFORMANT: Camille F Gelardo — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — over 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22. DATE SIGNED: 10-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
23d. LOCATION (City or town) (County) (State): Washington D. C.
24. FUNERAL DIRECTOR: F Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4291 Item #9 Film #G394 10/27/67 ph

Item #2 Film #G394 11/6/67 ph

CERTIFICATE OF DEATH

14296

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVERDALE
c. LENGTH OF STAY IN 1b: 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): E. LELAND MEMORIAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY P.G
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON // Lewisdale
d. STREET ADDRESS: 2302 Drexel St. KENSINGTON /// NSNG. HOME
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First KATHERINE; Middle W.; Last GILL
4. DATE OF DEATH: Month 10; Day 14; Year 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-27-86
9. AGE (In years if under 1 year): 80/80 — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): TEXAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES GILL
14. MOTHER'S MAIDEN NAME: MC CORMICK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): UNKN. (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 579 44 9185
17. INFORMANT: HOSPITAL RECORDS — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO
(b): Arteriosclerotic Heart disease
(c): Uremia & Chronic Nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: Minutes — 7 — 0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): S/P carcinoma of right inguinal hernia - M. Ostrich
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-11, 1967, to 10-14, 1967, that (I) (we) last saw the deceased alive on 10-14 1967, and that death occurred at 11:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: R. F. Wilkinson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): R. F. WILKINSON
22d. ADDRESS: 1400 Queensburg Rd. Riverdale, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-18-67
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY
23d. LOCATION (City or Town) (County) (State): WASHINGTON D. C.
24. FUNERAL DIRECTOR: GASCH'S — ADDRESS: HYATTSVILLE, MARYLAND
25a. REC'D BY REGISTRAR DATE: OCT 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

14292

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: Hamilton Hotel ~~University Nursing Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theo — Middle: Claire — Last: Glenn
4. DATE OF DEATH: Month: 10 — Day: 9 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/11/90
9. AGE (In years last birthday): 77 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Secretary-Wm. Green, AFL
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Glenn
14. MOTHER'S MAIDEN NAME: Emma Lawyer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 579-01-2486
17. INFORMANT: decedent — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO (b): Arteriosclerotic heart disease — unknown
DUE TO (c): Generalized arteriosclerosis — unknown
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old cerebrovascular accident; old anterior myocardial infarction, extensive, healed; hiatal hernia, large; cholelithiasis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from 8/11/, 1967, to 10/9/, 1967, that ☒ (we) last saw the deceased alive on 10/9/67, and that death occurred at 2:30PM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 10/9/67
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL CREMATION REMOVAL: Removal
23b. DATE THEREOF: 10/12/67
23c. NAME OF CEMETERY OR CREMATORY: Southlawn
23d. LOCATION (City or Town) (County) (State): Coshocton, Ohio

24. FUNERAL DIRECTOR: S.H. Hines Co. — ADDRESS: 2901 14 St. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR — DATE: OCT 13 1967
25b. REGISTRAR'S SIGNATURE: [signature]

1

14293

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14298

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6823 Riverdale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Glodeck

4. DATE OF DEATH: Month: Oct. — Day: 6 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 2, 1967
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: — Days: 4 — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Glodeck
14. MOTHER'S MAIDEN NAME: Joann B. Remeta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mr. John W. Glodeck (above address) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial hemorrhage, ventricular; cause undetermined. (Father) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (1) ~~[illegible]~~ attended the deceased from Oct. 2, 1967, to Oct. 6, 1967, that (I) ~~[illegible]~~ last saw the deceased alive on Oct. 6, 1967, and that death occurred at 1:35 AM from causes and on the date stated above.

22a. SIGNATURE: Bernardo Alvarado
M.D. ☐ ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Bernardo Alvarado, M. D.
22d. ADDRESS: 6201 Riverdale Rod. Riverdale, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/7/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Wash., D.C.

24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc. — ADDRESS: Mt. Rainier, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 9 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

7-

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form .PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14294

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14299

1 PLACE OF DEATH
a COUNTY: Prince George's — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11326 Cherry Hill Road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Prince George's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville 16-1
d STREET ADDRESS: 11326 Cherry Hill Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Wilma — Middle: Olean — Last: Goforth
4 DATE OF DEATH: Month: 10 — Day: 29 — Year: 19 67

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3-14-1935
9 AGE (In years last birthday): 32 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b KIND OF BUSINESS OR INDUSTRY: U.S. WELFARE, DEPT. D.C.
11 BIRTHPLACE (State or foreign country): OKLAHOMA
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: HENRY GOFORTH
14 MOTHER'S MAIDEN NAME: LOUELLA FULLER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 1958-1964
16 SOCIAL SECURITY NO: 443-32-6698
17 INFORMANT: MRS LUELLA GOFORTH — Address: OKLAHOMA CITY, OKLAHOMA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Gun shot wound of head
9 76X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Shot self in head with .22 cal. rifle.
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 1:00pm 10-29- 19 67
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f (City or town) (County) (State): same as #2

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 10-30-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: NOV. 3, 1967
23c NAME OF CEMETERY OR CREMATORY: SUNNY LANE CEM
23d LOCATION (City or Town) (County) (State): OKLAHOMA CITY, OKLAHOMA

24 FUNERAL DIRECTOR: W.W. CHAMBERS Co. — ADDRESS: RIVERDALE, MD
25a REC'D BY REGISTRAR DATE: NOV 2 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

4 FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14295

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14300

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2709 Kirkwood Place

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): West Hyattsville 16
d. STREET ADDRESS: 2709 Kirkwood Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Milton — Middle: P — Last: Gosnell
4. DATE OF DEATH: Month: 10 — Day: 2 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 25 April 1893
9. AGE (In years last birthday): 74 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Book Binder
10b. KIND OF BUSINESS OR INDUSTRY: Publishing Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Gosnell
14. MOTHER'S MAIDEN NAME: Mary Marshall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): 566
16. SOCIAL SECURITY NO: 579-03-740
17. INFORMANT: Harriet B. Gosnell — Address: same@ #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: over 1 yr.
DUE TO (b) Carcinoma of rectum — over 1 yr.
DUE TO (c)
154x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-3-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct.5, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor P. G's. Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons Hyattsville, Md. — ADDRESS:
25a. REC'D BY REGISTRAR: DATE OCT 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with DM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (8) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14296

CERTIFICATE OF DEATH

14301

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANHAM
c. LENGTH OF STAY IN 1b: 10 MOS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MAGNOLIA GARDENS NURS. HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT. #3 CHESTERTOWN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARIE — Middle: H. — Last: GRABENSTEIN

4. DATE OF DEATH: Month: OCT. — Day: 16 — Year: 1967

5. SEX: F

6. COLOR OR RACE: CAU.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/7/1905

9. AGE (in years last birthday): 61 yrs

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND MD

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Clifford Elliott

14. MOTHER'S MAIDEN NAME: Mary Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Anthony Grabenstein, Address: 2 Brooke Ave. Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1967 to Oct 16, 1967, that (I) (we) last saw the deceased alive on Oct 16 1967, and that death occurred at 12:15 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/16/67

22c. PHYSICIAN'S NAME (Type): Leon Rheutsky

22d. ADDRESS: Mt. Rainier, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/19/1967

23c. NAME OF CEMETERY OR CREMATORY: Sts. Peter & Paul's Cath Cem

23d. LOCATION (City or Town) (County) (State): Cumberland Alleg Md

24. FUNERAL DIRECTOR: John J. Hafer, Jr. — ADDRESS: 230 Balto Ave. Cumberland

25a. REC'D BY REGISTRAR: DATE: OCT 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1429

CERTIFICATE OF DEATH

F. 14302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 11days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
d. STREET ADDRESS: West Phila Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Samuel Middle A Last Gray
4. DATE OF DEATH: Month Oct., Day 26, Year 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3 Dec., 1904
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alexander Gray
14. MOTHER'S MAIDEN NAME: Julia Bowen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 579-16-0125
17. INFORMANT: Mrs. Geraldine Gray Address: 1400 Westphalia Forestville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis (Infarction) — INTERVAL BETWEEN ONSET AND DEATH
332 X
DUE TO (b) ~~Cerebral thrombosis~~ Pneumonia
DUE TO (c) Generalized atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour & m p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 15, 1967, to Oct. 26, 1967, that (I) (we) last saw the deceased alive on Oct. 26, 1967, and that death occurred ~~[illegible]~~ 3:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Fidel J. Quintana M.D. ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: Oct. 26, 1967
22c. PHYSICIAN'S NAME (Type): Fidel J. Quintana, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-31-67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Park
23d. LOCATION (City or Town) (County) (State): Landover Md.
24. FUNERAL DIRECTOR: Kellum 4339 Hunt Pl. NE
ADDRESS:
25a. REC'D BY REGISTRAR DATE OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (a) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14299 Items #9, 11, 12, 13 & 14 Film #1325 - 17-67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14303

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d. STREET ADDRESS: Post Office Box #121
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: Daniel Middle: Mathew Last: Griffin
4 DATE OF DEATH: Month: 10 Day: 13 Year: 19 67
5 SEX: male
6 COLOR OR RACE: Negro
7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: 11-9-01
9 AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Daniel Griffin
14. MOTHER'S MAIDEN NAME: Susie Thomas
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17 INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Arteriosclerotic Heart Disease — over 2 mo.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
42

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
Diabetes Mellitus for over nine years

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town or county):
22. DATE SIGNED: 10-14-67

23a BURIAL, CREMATION, REMOVAL (Specify): [illegible]
23b DATE THEREOF: 10-16-67
23c NAME OF CEMETERY OR CREMATORY: Harmony
23d LOCATION (City or Town) (County) (State): Sandoson, Md
24 FUNERAL DIRECTOR: Frazier 389 B.I. [illegible]
ADDRESS:
25a REC'D BY REGISTRAR DATE: OCT 17 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2143. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14298

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14304

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Clinton Medical Center

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 514 Independence Ave., 47
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Karla — Middle Joe — Last ~~Gutenberg~~ Gudenberg
4. DATE OF DEATH: Month 10 — Day 14 — Year 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ WIDOWED ☐ NEVER MARRIED ☒ DIVORCED ☐
8. DATE OF BIRTH: 17 Feb., 1963
9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Karl Gudenberg
14. MOTHER'S MAIDEN NAME: Anita Chidichimo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Karl Gudenberg father — Address: same as 2b

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Laceration of beain — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Passenger, thrown from car in collision.
20c. TIME OF INJURY: Hour 8:20 a.m. P.M. — Month 8 — Day 14 — Year 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): St. Rt. 5
20f. (City or town): Clinton — (County): P.G. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 10-15-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 10/16/67
23c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory
23d. LOCATION (City or Town): Washington, D.C. — (County) — (State)

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: 300-4th N.E. Wash. D.C.
25a. RECORDED BY REGISTRAR — DATE: OCT 17 1967
25b. REGISTRAR'S SIGNATURE: Wesley Judge

1

14305

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14305

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY: PRINCE GEORGE'S MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berwyn Heights
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8720 - 62 Ave

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE: Maryland b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Berwyn Heights
d. STREET ADDRESS: 8720 — 62nd Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First ALICE Middle L Last HADLEY
4. DATE OF DEATH: Month Oct Day 9 Year 1967
5 SEX: Female
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: MAY 15, 1877
9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Philadelphia, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James Smith
14. MOTHER'S MAIDEN NAME: Margaret S. Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO.: 220-46-6016
17 INFORMANT: MRS ALICE FLAHARTY (Daughter) Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL PULMONARY EDEMA secondary — INTERVAL BETWEEN ONSET AND DEATH: 20 MIN
DUE TO (b) to Acute Congestive Heart Failure
DUE TO (c) Arterio/sclerotic CARDIO VASCULAR DISEASE — 5 yr +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1962 19 to Oct 1967, that (I) (we) last saw the deceased alive on Oct 9 1967, and that death occurred at 11:45 p M, from causes and on the date stated above

22a. SIGNATURE: W L Etienne M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/9/67
22c. PHYSICIAN'S NAME (Type): W.L. ETIENNE, M.D.
22d. ADDRESS: COLLEGE PARK Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct. 12, 1967
23c NAME OF CEMETERY OR CREMATORY: Fairfax Cemetery
23d LOCATION (City or Town) (County) (State): Fairfax, Virginia
24. FUNERAL DIRECTOR: Everly Funeral Home By [illegible] Mgr. ADDRESS: Fairfax, Va.
25a. REC'D BY REGISTRAR DATE: OCT 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14301

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14306

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
d. STREET ADDRESS: 1109 57th. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16.1

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Hallman
4. DATE OF DEATH: Month: 10 — Day: 1 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 25 Sept. 1895
9. AGE (in years lost birthday): 72 yrs
UNDER 1 YEAR: Months — Days
UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd. Elevator Engr.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Phil. Pa.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Washington Hallman
14. MOTHER'S MAIDEN NAME: Catherine McGinley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes WWI (If yes give war or dates of service): 12-9-17 1-31-19
16. SOCIAL SECURITY NO:
17. INFORMANT: Wife — Address: Margaret J. Hallman Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — over 2 yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 10-2-67

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 6-1967
23c. NAME OF CEMETERY OR CREMATORY: Fern Wood Cemetery
23d. LOCATION (City or Town) (County) (State): Fern Wood, Pa.
24. FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Simmons Bros.-1601-Good Hope Rd SE Wash DC
25a. REC'D BY REGISTRAR: DATE OCT 4 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14307

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
d. STREET ADDRESS: 8205 Milligan Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: David — Middle: Spencer — Last: Alias Hunigan Hamm
4. DATE OF DEATH: Month: 10 — Day: 8 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 17 June 1943
9. AGE (In years last birthday): 24 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrican
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William A Hamm
14. MOTHER'S MAIDEN NAME: Betty Sue Manuel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: William A. Hamm — Address: Same As 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Bilateral hemothorax — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Laceration of spleen and left kidney
DUE TO
(c)
8234
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver of car which ran off road and hit a guard rail
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m.: 10:30am 10-8- 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Wash. Beltway, north of Rt. 202
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-9-67

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/11/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges, Maryland
24. FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home — ADDRESS: 4308 Suitland Road, Suitland, Maryland
25a. REC'D BY REGISTRAR: DATE OCT 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14203 Item #1b &d File #0394 11/6/67 ch 14308

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pr. Geo. General Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Hill, Md.
d. STREET ADDRESS: 7404 Oxon Hill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOMER Middle H. Last HANBACK
4. DATE OF DEATH: Month 10 Day 23 Year 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 5-11-1885
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): Warrenton, VA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOHN W. HANBACK
14. MOTHER'S MAIDEN NAME: ANNA LEE BALL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-09-1397
17. INFORMANT: MABEL M. AMISS Address: 7404 OXON HILL Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure Acute — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b) Congestive Heart Failure Chronic — Months
DUE TO
(c) Emphysema — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 3/22, 1967, to 10/23, 1967, that (I) (we) last saw the deceased alive on 3/19 1967, and that death occurred at 7:45 AM from the causes and on the date stated above.

22a. SIGNATURE: Thomas L. Fieldson M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/23/67
22c. PHYSICIAN'S NAME (Type): THOMAS LARKIN FIELDSON
22d. ADDRESS: Brandywine, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-25-67
23c. NAME OF CEMETERY OR CREMATORY: BEALTON CEMETERY
23d. LOCATION (City, town or county) (State): BEALTON, VA.

24. FUNERAL DIRECTOR: J. Wm. Lee & Sons
ADDRESS:
25a. REC'D BY REGISTRAR DATE OCT 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14304 Item #7 Film #G393 10/12/67 ph

CERTIFICATE OF DEATH

14309

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CLINTON Community Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
d. STREET ADDRESS: 10604 Ridge Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ELCANY — Middle C. — Last HARLESS

4. DATE OF DEATH: Month October — Day 3 — Year 1967

5 SEX: MALE
6. COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 10-3-88
9 AGE (in years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): IRON WORKER
10b KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11 BIRTHPLACE (County & State, or foreign country): MATHIAS, WEST VA.
12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: MOSES HARLESS
14. MOTHER'S MAIDEN NAME: MARY MOYER

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): NONE
16 SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: PAUL HARLESS — Address: 233 NO. ST. JOHNS LANE ELLICOTT CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ATRIAL FIBRILLATION — INTERVAL BETWEEN ONSET AND DEATH: UNK.
DUE TO (b): A.S.H.D. — UNK.
DUE TO (c): Congestive Heart Failure — UNK.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Extreme old age. Hydrotherapy
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/30, 1967, to 10/3, 1967, that (I) (we) last saw the deceased alive on 10/3, 1967, and that death occurred at 4:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert Merkle M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS ☒
22b DATE SIGNED: 10/8/67
22c. PHYSICIAN'S NAME (Type): ROBERT MERKLE
22d. ADDRESS: 116 McKENDRICK ROAD BRANDYWINE, MD

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/6/67
23c. NAME OF CEMETERY OR CREMATORY: WASH. NATL.
23d. LOCATION (City or Town) (County) (State): SUITLAND. MD.

24. FUNERAL DIRECTOR: W.W. CHAMBERS CO. INC.
ADDRESS: 517 K ST. S.E. WASH. D.C.
25a. REC'D BY REGISTRAR DATE OCT 6 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4-67) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14305

CERTIFICATE OF DEATH

14310

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 9514 Rhode Island Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — M; Middle — Elinor; Last — Harr
4. DATE OF DEATH: Month — October; Day — 25; Year — 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/11/88
9. AGE (In years last birthday): 79 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Scaggs, Pinkney
14. MOTHER'S MAIDEN NAME: Larrick, Cora
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 577-24-2950
17. INFORMANT: D Scaggs, Lucy, 9514 Rhode Is. Av. — Address: College Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Hypertension/arteriosclerotic Cardiovas disease
DUE TO (b) Bilateral Bronchopneumonia
DUE TO (c) Toxic Renal failure secondary to #1 above
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1967 to Oct 25, 1967, that (I) (we) last saw the deceased alive on Oct 25 1967, and that death occurred at 11 A.M., from causes and on the date stated above

22a. SIGNATURE: W. Etienne M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/27/67
22c. PHYSICIAN'S NAME (Type): W. L. ETIENNE
22d. ADDRESS: College Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 28, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: St John's Cemetery
23d. LOCATION (City or Town) (County) (State): Beltsville Pro Geo Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

Items 18&21 Film 396
12-22-67 ams

1

FOR STATE HEALTH DEPT.

4306

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14311

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 19 min.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville-Kentland, Md.
d. STREET ADDRESS: 2914 Markham Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Louise — Last: Hester
4. DATE OF DEATH: Month: 10 — Day: 8 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 21 Feb. 1925
9. AGE (In years last birthday): 42 yrs
If UNDER 1 YEAR: Months — Days
If UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Russell A. Brown sr
14. MOTHER'S MAIDEN NAME: Mabel M Pressel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Edward J Hester — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Aspiration of gastric contents
DUE TO (c) Etiology undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE NOTED IN GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-9-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
23d. LOCATION (City or Town) (County) (State): Donnellsville Clark co Ohio

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 11 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5)
6M 1/67

1

4307

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Laurel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 803 Fountain Row
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene — Middle: Leola — Last: Hicks

4. DATE OF DEATH: Month: Oct — Day: 9 — Year: 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 11 1894
9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Counselor
10b. KIND OF BUSINESS OR INDUSTRY: D.C. Government
11. BIRTHPLACE (County & State, or foreign country): Howard Co. Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel A. Leister
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Fulton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Margaret Nicholson — Address: 903 Whitelaw Laurel Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): ACUTE CONGESTIVE HEART FAILURE
DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 48 hours

4221

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 OCT, 1967, to 9 OCT, 1967, that (I) (we) last saw the deceased alive on 8 OCT 1967, and that death occurred at 3:4 M, from causes and on the date stated above.

22a. SIGNATURE: Richard Compton M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11 OCT 67
22c. PHYSICIAN'S NAME (Type): J. Richard Compton, M. D.
22d. ADDRESS: 612 Main Street, Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-11-67
23c. NAME OF CEMETERY OR CREMATORY: Long Hill Cem
23d. LOCATION (City or Town) (County) (State): Laurel Md

24. FUNERAL DIRECTOR: DeWitt Donnelson — ADDRESS: Laurel Md
25a. REC'D BY REGISTRAR DATE: OCT 17 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15-14
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14309 — 14313

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL-Upper Marlborough
c. LENGTH OF STAY IN 1b: 16 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Chelsea Farm, Box 2338

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-Upper Marlborough
d. STREET ADDRESS: Chelsea Farm, Box 2338
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Leon — Middle: --- — Last: Hnativ
4. DATE OF DEATH: Month: October — Day: 20, — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan.10, 1908
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tobacco Farming
10b. KIND OF BUSINESS OR INDUSTRY: Tenent
11. BIRTHPLACE (County & State, or foreign country): Ukrania
12. CITIZEN OF WHAT COUNTRY? Ukrania
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): -------
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anna Hnativ- Same as Item #2. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 hrs
DUE TO (b) Carcinoma of lung — 4 hrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 1967 to 20 Oct, 1967, that (I) (we) last saw the deceased alive on 20 Oct 1967, and that death occurred at 7:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R B Sasscer M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 10/20/67
22c. PHYSICIAN'S NAME (Type): Dr. Robert B. Sasscer, M.D.
22d. ADDRESS: Upper Marlborough, Md. 20870

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/24/67
23c. NAME OF CEMETERY OR CREMATORY: Washington Nat'l Cem.
23d. LOCATION (City, town or county): Suitland (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ritchie Bros. Fun'l Home-Upper Marlboro, Md.
25a. RECD BY REGISTRAR DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M S 64

1

FOR STATE HEALTH DEPT.

14308

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14314

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Greenbelt
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Greenbelt Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Springs
d. STREET ADDRESS: 620 Pershing Drive ~~10120 New Hampshire Ave.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cornelia — Middle: A — Last: Holmead
4. DATE OF DEATH: Month: 10 — Day: 26 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-5-1883
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Holmead
14. MOTHER'S MAIDEN NAME: Alice G. Unkle
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 578-62-8430
17. INFORMANT: Nellie Fowler 10120 New Hampshire Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO Arteriosclerotic heart disease — over 2 yrs.
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of right hip - 9-26-67
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Fell at Nursing home
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m.: 8:00am 9-26- 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Green belt Nursing Home, Greenbelt, Md.
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-27-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 31, 1967
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.
24. FUNERAL DIRECTOR: C. Glen Carter — ADDRESS: 4134 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: NOV 2 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

14310

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14315

1 PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 25 days14½hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colmar Manor
d. STREET ADDRESS: 3404-39th Place 20722
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Austin Middle: M. Last: Holtzclaw
4. DATE OF DEATH: Month: October Day: 17 Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/18/01
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired-unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Holtzclaw, Luther J.
14. MOTHER'S MAIDEN NAME: Corter, Tacy Emmia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 578-24-9457
17. INFORMANT: hospital records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): 203 x
DUE TO (b): MULTIPLE MYELOMA
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 6 MOS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-21, 1967, to 10-17, 1967, that (I) (we) last saw the deceased alive on 10-16 1967, and that death occurred at 2 A.M., from causes and on the date stated above.

22a. SIGNATURE: C. J. Houmann M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-17-67
22c. PHYSICIAN'S NAME (Type): C. J. HOUMANN
22d. ADDRESS: RIVERDALE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/18/67
23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION (City or Town) (County) (State): Leesburg Va.
24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

jwb VR A15 (4) 25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14311

CERTIFICATE OF DEATH

14316

1 PLACE OF DEATH
a. COUNTY: Prince Geo. Forestville MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Regent Rehab. Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville Md.
d. STREET ADDRESS: 5820 Reed St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LeRoy Middle: Last: Howard
4. DATE OF DEATH: Month: October Day: 27 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-27-04
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Howard
14. MOTHER'S MAIDEN NAME: Catherine Downing
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Address: Bessie Howard-wife-5820 Reed St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Anoxia - Pulmonary Collapse. — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Ca of lungs (metastatic) — 1960
DUE TO
(c): Obstruction of airway. — 1967
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-25, 1967 to 10-27-1967 that (I) (we) last saw the deceased alive on 10-26-1967, and that death occurred at 3:30 M, from causes and on the date stated above.

22a. SIGNATURE: [illegible] H. Reeder M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-27-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/31/67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park
23d. LOCATION (City or Town) (County) (State): Maryland
24. FUNERAL DIRECTOR: John T. Stewart Jr. ADDRESS: Stewart Funeral Home-4001 Benning Rd., N.E.
25a. REC'D BY REGISTRAR DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Yuggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14312

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14317

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AF BASE
c. LENGTH OF STAY IN 1b: 3 HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MALCOLM GROW USAF HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTH BEACH
d. STREET ADDRESS: RT 1, BOX 254
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle L — Last HUARD
4. DATE OF DEATH: Month OCTOBER — Day 26 — Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 23 Nov 1921
9. AGE (In years last birthday): 45 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NA
11. BIRTHPLACE (County & State, or foreign country): RICHMOND, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ALLEN HARLOW
14. MOTHER'S MAIDEN NAME: OLLIE MAE ROBINSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): NA
16. SOCIAL SECURITY NO: UNK
17. INFORMANT: Robert F. Huard — HUSBAND — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): probable myocardial infarct — 3 hours
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the attending physician~~) attended the deceased from 26 Oct, 1967, to 26 Oct, 1967, that (I) (~~we~~) last saw the deceased alive on 26 Oct 1967, and that death occurred 0230 AM, from causes and on the date stated above.

22a. SIGNATURE: Louis G. Martin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 26 Oct 67
22c. PHYSICIAN'S NAME (Type): LOUIS G. MARTIN, CAPT, USAF, MC
22d. ADDRESS: Malcolm Grow USAF Hospital, Andrews AFB, Wash DC 20331

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/30/1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia
24. FUNERAL DIRECTOR: W.W.Chambers, Co. Inc. — ADDRESS: 517 11th St. S.E. Washington, D.C.
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
25M 1/67

1

14318

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14318

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince Georges
c. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN (b): 20 hrs. 7 days, 10hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, Maryland
d. STREET ADDRESS: 3121 Madison Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura Middle: Mae Last: Iager
4. DATE OF DEATH: Month: October Day: 12 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/4/12
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (County & State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wm H Thomas
14. MOTHER'S MAIDEN NAME: Elizabeth Turnbull
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577 01 3719
17. INFORMANT: hospital records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 2 mo
5210
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Gastritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 4-22, 1951 to Oct 12, 1967, that (I) (we) last saw the deceased alive on Oct 11 1967, and that death occurred at 1:32 P.M., from causes and on the date stated above.

22a. SIGNATURE: L W Malin MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/12/67
22c. PHYSICIAN'S NAME (Type): L W MALIN MD
22d. ADDRESS: Riverdale, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: George Washington
23d. LOCATION (City or Town) (County) (State): Hyattsville Pro Geo Md.
24. FUNERAL DIRECTOR: Gasch's Funeral Home — ADDRESS: 4739 Belts Ave Hyattsville
25a. RECD BY REGISTRAR DATE: OCT 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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4314 Item #9 Film #G394 11/13/67 pb

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14319

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
d. STREET ADDRESS: 6118 Odell Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Frederick — Middle: — Last: Jackson

4. DATE OF DEATH: Month: Oct. — Day: 7, — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: Colored
7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8 DATE OF BIRTH: Nov 17-1875
9 AGE (In years last birthday): 92 91 yrs
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance man
10b KIND OF BUSINESS OR INDUSTRY: Navy Yard
11 BIRTHPLACE (County & State, or foreign country): Glendale md
12 CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Austin Jackson
14. MOTHER'S MAIDEN NAME: Charlotte Mathews

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —
16 SOCIAL SECURITY NO.:
17 INFORMANT: Elsie Camp — Address: Same as 2D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO (b): Arteriosclerotic Heart Disease — 10 yr
DUE TO (c): Essential Hypertension — 15 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diverticulosis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — hour a.m. p.m. — 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) ~~(this hospital)~~ attended the deceased from ____, 19__, to Oct. 7, 19 67, that (I) ~~(we)~~ last saw the deceased alive on ____ 19__, and that death occurred at 10:50 AM, from causes and on the date stated above

22a SIGNATURE: Henry A. Wise Jr. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Henry A. Wise, Jr., M.D.
22d ADDRESS: 13008-9th Street, Bowie, Md. 20715

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10-11-67
23c NAME OF CEMETERY OR CREMATORY: Glendale Cem.
23d LOCATION (City or Town) (County) (State): Glendale, Md

24 FUNERAL DIRECTOR: Henry S. Washington & Sons — **ADDRESS**: 4925 Deane ave N.E.
25a REC'D BY REGISTRAR DATE: OCT 16 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

Items 18&21 Film 396
1-8-68 ams
4315

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14330

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN (b): DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 606 Beacon Road
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Dorothy; Middle: Suzanne; Last: Johnson
4. DATE OF DEATH: Month: 10; Day: 13; Year: 67 (19)
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 4-1-29
9. AGE (In years last birthday): 38 38 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Typist
10b. KIND OF BUSINESS OR INDUSTRY: NASA
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Reginald William Smith
14. MOTHER'S MAIDEN NAME: Dorothy Shand
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO: YES
17. INFORMANT: Mr. William F. Smith — Address: 901 Northampton Dr. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute pulmonary edema
DUE TO
(b): Cause undetermined
DUE TO
(c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year; Hour, a.m. p.m. 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above held on Autopsy [X], Inspection [X], Inquiry [X] and in my opinion death resulted from Natural cause [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X]

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland
Address (Street, city, town, or county)
22. DATE SIGNED: 10-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: George Washington Cem.
23d. LOCATION (City or Town) (County) (State): Hyattsville, Maryland
24. FUNERAL DIRECTOR: Thomas W. Humphrey, Inc.
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. RECD BY REGISTRAR: DATE OCT 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

5 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4316

CERTIFICATE OF DEATH

14321

1 PLACE OF DEATH a. COUNTY: PRINCE GEORGE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PINE VIEW GARDENS MARYLAND
c. LENGTH OF STAY IN Ib: 9/12/67-10-1-67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PINE VIEW GARDENS

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
d. STREET ADDRESS: 6902 DIANE DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Florence Middle Johnson Last
4. DATE OF DEATH: Month 10 Day 1 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-26-01
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): West moreland Co Virginia
12. CITIZEN OF WHAT COUNTRY? Yes
13. FATHER'S NAME: JAMES HENRY CONROY
14. MOTHER'S MAIDEN NAME: VIRGINIA DAIE SANFORD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N/A (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 230-03-6053
17. INFORMANT: VIRGINIA SIZZAK Address: SAME AS Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral hemorrhage
DUE TO (b): Cerebrovascular hypertension disease
DUE TO (c): Arteriosclerosis advanced
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-2, 1967 to 10-1, 1967 that (I) (we) last saw the deceased alive on 10-1, 1967, and that death occurred at 12:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Alfred R Lapin, MD
M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): ALFRED R. LAPIN, MD
22d. ADDRESS: CLINTON, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried
23b. DATE THEREOF: Oct. 3, 1967
23c. NAME OF CEMETERY OR CREMATORY: Providence Meth. Ch. Cem.
23d. LOCATION (City or Town) (County) (State): Montrose, Virginia

24. FUNERAL DIRECTOR: W R Sanford
ADDRESS: Sanford Funeral Home Montross Va
25a. REC'D BY REGISTRAR DATE OCT 25 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14317

CERTIFICATE OF DEATH

14322

1 PLACE OF DEATH
a. COUNTY: Pr. George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Regent Rehabilitation Center

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Pr. Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont Hghts., Md.
d. STREET ADDRESS: 902 59th ~~XXXXX~~ Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Roxie; Middle:; Last: Jones
4. DATE OF DEATH: Month 10; Day 12; Year 1967
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-6-84
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ~~XXXXX~~ Louis Shellman
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Lottie Skipper — Address: 902-59th Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Rt Upper Lobe — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(b): C.V.A. c̄ Rt Hemiparesis & Tracheostomy — INTERVAL BETWEEN ONSET AND DEATH: 9 wks
DUE TO
(c): Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/6/67 to 10/12/67, that (I) (we) last saw the deceased alive on 10/12/1967, and that death occurred at 5:30 PM from causes and on the date stated above.

22a. SIGNATURE: Kelvin L. Minchin M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 10/12/67
22c. PHYSICIAN'S NAME (Type): KELVIN L MINCHIN
22d. ADDRESS: 6400 MARLBORO PIKE SE WASH DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-12-67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Park
23d. LOCATION (City or Town) (County) (State): Landover Md.
24. FUNERAL DIRECTOR: Rollins Funeral Home Inc. — ADDRESS: 4339 Hunt NE
25a. REC'D BY REGISTRAR DATE OCT 16 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4318 14323

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Prince Georges General Hospital — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STREET: 1720 Brightseat Rd. b. COUNTY: #203
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Maryland
d. STREET ADDRESS: 1720 Brightseat Rd. #203
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Joanne — Middle: M — Last: Karmel
4. DATE OF DEATH: Month: October — Day: 24 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7/3/47
9. AGE (In years last birthday): 20 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Earl J Thompkinson
14. MOTHER'S MAIDEN NAME: Irma L Witten
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Donald L Karmel — Address: Landover, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Generalized Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2:1X
DUE TO (b) Perforation of Stomach - Fundus — 3 days
DUE TO (c) Hodgkin's Lymphoma Stomach — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1967, to 24 Oct 1967 that (I) (we) last saw the deceased alive on 24 Oct 1967, and that death occurred at 2:15 P.M. from causes and on the date stated above

22a. SIGNATURE: Thomas M. Hutchins M.D. — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: 10-24-67
22c. PHYSICIAN'S NAME (Type): Dr. Thomas M. Hutchins
22d. ADDRESS: 7315 Landover Rd., Landover, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City or Town) (County) (State): Suitland Pro Geo Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14319 Item #11 Film #G3 767 ph

CERTIFICATE OF DEATH

14324

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 4310 Kaywood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby; Middle: Boy; Last: Kelly
4. DATE OF DEATH: Month: Oct.; Day: 17; Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 17, 1967
9. AGE (In years last birthday): — yrs; IF UNDER 1 YEAR: Months / Days / Hours: 2 / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Cheverly, P.G. Co.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Lidden Kelly
14. MOTHER'S MAIDEN NAME: Janet Lorsey Lindell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH

7615

IMMEDIATE CAUSE (a) Immaturity, 600 mgs.
DUE TO
(b) Primary atelectasis of lungs, bilateral
DUE TO
(c) Cephalohematoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(the hospital)~~ attended the deceased from Oct. 17, 19 67, to Oct. 17, 19 67, that (I) ~~(the)~~ last saw the deceased alive on Oct. 17, 1967, and that death occurred at 3:30 PM, from causes and on the date stated above

22a. SIGNATURE: Harry E. Altman M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Oct. 19, 1967
22c. PHYSICIAN'S NAME (Type): Harry E. Altman, M. D.
22d. ADDRESS: 2025 Eye St., NW. Washington, D. C. 20006

23a. BURIAL, CREMATION, REMOVAL (Specify): ☒
23b. DATE THEREOF: 10-21-67
23c. NAME OF CEMETERY OR CREMATORY: Prince George's Hospital
23d. LOCATION (City or Town) (County) (State): Cheverly, Md.

24. FUNERAL DIRECTOR: HARRY W. BENN, JR., Cheverly, Md.
ADDRESS:
25a. REC'D BY REGISTRAR DATE OCT 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14320 14325

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6357 64th. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: Keola Last:
4. DATE OF DEATH: Month 10 Day 18 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-9-1919
9. AGE (In years last birthday): 47 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Eng.
10b. KIND OF BUSINESS OR INDUSTRY: Philco-Ford Corp.
11. BIRTHPLACE (State or foreign country): HAWAII
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: WILLIAM K. KEOLA
14. MOTHER'S MAIDEN NAME: MATILDA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ------
16. SOCIAL SECURITY NO.: 575-05-8398
17. INFORMANT: Anne L. Keola Wife Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-18-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 10-21-67
23c. NAME OF CEMETERY OR CREMATORY: William. Mex Tuary
23d. LOCATION (City or Town) (County) (State): Honolulu Hawaii
24. FUNERAL DIRECTOR: GASCH'S ADDRESS: HYATTSVILLE, MD.
25a. REC'D BY REGISTRAR DATE: OCT 23 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14321

CERTIFICATE OF DEATH

14326

1 PLACE OF DEATH
a. COUNTY Pr. Geo. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor
d. STREET ADDRESS 3506 37th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARY Middle HELEN Last KIDWELL
4. DATE OF DEATH Month Oct. Day 23 Year 19 67

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 7/5/11
9. AGE (In years last birthday) 56 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Checker
10b. KIND OF BUSINESS OR INDUSTRY Dept. Store
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James M. Armiger
14. MOTHER'S MAIDEN NAME Lelia M. Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 217 26 5214
17. INFORMANT Florence W. Kidwell Address Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
1201
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that (1) (this hospital) attended the deceased from 1952, 19 to Oct 22, 1967, that (1) last saw the deceased alive on Oct 22 1967, and that death occurred at 8:10 A.M. from causes and on the date stated above.

22a. SIGNATURE [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 10/26/67
22c. PHYSICIAN'S NAME (Type) Robert Wingfield
22d. ADDRESS Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 10/26/67
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Church Ceme.
23d. LOCATION (City or Town) Croom (County) Pr. Geo. (State) Md.

24. FUNERAL DIRECTOR Francis Gasch's Sons ADDRESS Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE OCT 30 1967
25b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Deputy Med. Exam.; Dr. John Kehoe Notified and Released.

VR A15 (4) 25M 1/67 jwb

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4322 — 143327

1. PLACE OF DEATH
a. COUNTY: Prince Georges Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville — Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Colimbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3300 Connecticut Ave. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR — Middle — Last KINGSTON
4. DATE OF DEATH: Month 10 — Day 24 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-24-1888
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Marine Corps
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John C. Kingston
14. MOTHER'S MAIDEN NAME: Alice Murphy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 579-34-3686
17. INFORMANT: Mrs. Edwin A. Rankin — Address: 3040 Legation St. N.W. Wash.D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE PENIS C — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO (b) GENERALIZED METASTASES
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-29, 1963, to 10-24, 1967, that (I) (we) last saw the deceased alive on 10-23 1967, and that death occurred at 7:30 M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas F Collins — M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): THOMAS F. COLLINS
22d. ADDRESS: 322 H ST NE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-27-1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR: Joseph gawler's sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR — DATE: OCT 26 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14323

CERTIFICATE OF DEATH

14328

1 PLACE OF DEATH a. COUNTY: Prince Georges — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE

c. LENGTH OF STAY IN 1b: 10 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Manor 4722 LaSalle Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Washington D.C. — b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

d. STREET ADDRESS: 1415 Otis Street N.E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mrs. Middle: Marie Last: A Kinzelman

4. DATE OF DEATH: Month 10 Day 27 Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 8/3/78

9. AGE (In years if last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl F. Happel

14. MOTHER'S MAIDEN NAME: Eliz. Schmitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 579-66-1161

17. INFORMANT: L. M. Regis — Address: Carroll Manor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY

332X

IMMEDIATE CAUSE (a): Cerebral thrombosis — 7 days

DUE TO (b): Arteriosclerosis, general — Years

DUE TO (c): + Arteriosclerotic heart disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Essential hypertension, benign; Osteo-arthritis, general, mild

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1960, 19__, to Oct 27, 1967, that (I) (~~we~~) last saw the deceased alive on Oct 26 1967, and that death occurred at 9:30 p M, from causes and on the date stated above.

22a. SIGNATURE: John F Brennan Jr. M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Oct 27/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/30/67

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City or Town) (County) (State): Wheaton, Maryland

24. FUNERAL DIRECTOR: Jas. T. Ryan, Inc. — ADDRESS: 317 Pa. Ave., SE DC3

25a. RECD. BY REGISTRAR — DATE: OCT 31 1967

25b. REGISTRAR'S SIGNATURE: Florence Yeager

1

14324

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14329

1 PLACE OF DEATH a. COUNTY: Prince Georges MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale

c. LENGTH OF STAY IN 1b: two days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berwyn Heights

d. STREET ADDRESS: 8508 63rd Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Tuesnelda Middle: Wilhelmina Last: Langley

4. DATE OF DEATH: Month 10 Day 26 Year 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/30/85

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife - Ret.

10b KIND OF BUSINESS OR INDUSTRY: At Home

11 BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Koepper, Adolph

14 MOTHER'S MAIDEN NAME: Whitram, Carlina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Foster, Eleanor, 8508 63rd Ave. Address: Berwyn Heights

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cerebral Thrombosis (R) c left

DUE TO (b): Hemiplegia

DUE TO (c): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAM.NER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 14 67, 19 to Oct 26 67, 19, that (I) (we) last saw the deceased alive on Oct 26 1967, and that death occurred at 4:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: W L Etienne M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 10/26/67

22c. PHYSICIAN'S NAME (Type): W.L. ETIENNE

22d ADDRESS: College Park Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Oct. 30, 1967

23c NAME OF CEMETERY OR CREMATORY: Congressional Cemetery

23d LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: W. W. CHAMBERS CO ADDRESS: Riverdale, Md W. W. Chambers Riverdale Md.

25a DATE RECD BY REGISTRAR: NOV 1 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 (original) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15325 Items #c & d Film G 11/21/67 Item 2C Film G 11/21/67

CERTIFICATE OF DEATH

14330

1. PLACE OF DEATH
a. COUNTY: Prince Georges County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANHAM
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Magnolia Gardens 9104 Good luck Rd Lanham

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~New Carrollton~~ Hyattsville
d. STREET ADDRESS: 6117 86th Ave. ~~9104 Good luck Rd Lanham~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Theresa Middle: Marie Last: Law

4. DATE OF DEATH: Month: Oct. Day: 15 Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐
8. DATE OF BIRTH: Sept 16 - 1892
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Danbury - Conn.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Henry
14. MOTHER'S MAIDEN NAME: Margaret Brennan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edgar Law Son
Address: 6117 - 86th Ave. New Carrollton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): [illegible]
DUE TO
(b): [illegible]
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 5 minutes / 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/10, 19 67 to 10/15, 1967, that (I) (we) last saw the deceased alive on 10/15, 19 67, and that death occurred at 5:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: OCT. 15-67
22c. PHYSICIAN'S NAME (Type): Leon R. Levitsky
22d. ADDRESS: 3408 R.I. Ave. Mt. Rainier, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-19-67
23c. NAME OF CEMETERY: Lakeview
23d. LOCATION (City or Town) (County) (State): Bridgeport, Conn.

24. FUNERAL DIRECTOR: Gasch's
ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14226 — 1-4331

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Madison Manor Nursing Home 5201 52nd Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 417 Madison Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rose — Middle: D. — Last: Lawrenson
4. DATE OF DEATH: Month: October — Day: 21 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 2, 1887
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Karl Dorma
14. MOTHER'S MAIDEN NAME: Rosa E. Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-62-3208
17. INFORMANT: Mrs. Frances L. Pitman — Address: 417 Madison St. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Day — Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-19, 1967 to 10-24, 1967, that (I) (we) last saw the deceased alive on 10-17 1967, and that death occurred at 6:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Donald C. Edken M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/21/67
22c. PHYSICIAN'S NAME (Type): DONALD C. EDKEN
22d. ADDRESS: Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/24/67
23c. NAME OF CEMETERY OR CREMATORY: St. Lincoln Cemetery
23d. LOCATION (City, town or county): Prince George Co. (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ben Carter
ADDRESS: Carter & Implan No. 3 24 Georgia Avenue N.W.

25a. REC'D BY REGISTRAR DATE: OCT 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1'67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4327

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

143332

1. PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6213 Kennedy St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Idella Middle: Last: Lee
4. DATE OF DEATH: Month 10 Day 5 Year 1967
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-25-1898
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Fuller
14. MOTHER'S MAIDEN NAME: Martha Ashe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.
17. INFORMANT: Betty Massey - 6213 Kennedy Street Address: Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cerebral vascular occlusion — INTERVAL BETWEEN ONSET AND DEATH: over 2 mo.
332X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/11/67
23c. NAME OF CEMETERY OR CREMATORY: CHURCH CEMETERY
23d. LOCATION (City or town) (County) (State): BAINBRIDGE, GA.
24. FUNERAL DIRECTOR: JOHN T. RHINES CO. FUNERAL HOME ADDRESS: 3015 12TH ST. N. E.
25a. REC'D BY REGISTRAR DATE: OCT 10 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14328

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14333

1 PLACE OF DEATH
a. COUNTY: Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hillside 16-1
d. STREET ADDRESS: 6003 N. St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Myra Middle Christine Last Liverette

4 DATE OF DEATH: Month 10 Day 14 Year 19 67

5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 12 June 1917
9 AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Schaefer
14. MOTHER'S MAIDEN NAME: Susie Sutherland

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harry E. Liverette Address: Same As # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — over 1 yr.
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, MD, Riverdale, Md.
Address (Street, city, town or county)
22. DATE SIGNED: 10-14-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/17/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Suitland, Prince Georges, Md

24 FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home
ADDRESS: 4308 Suitland Road, Suitland, Maryland

25a. REC'D BY REGISTRAR DATE OCT 18 1967
25b. REGISTRAR'S SIGNATURE: Clementine Quidel

VR A15ME(B)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

4329

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14334

1. PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~xxx~~ Beltsville 16-1
d. STREET ADDRESS: 11129 Emack Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Earl Middle: J. Last: Lombard
4. DATE OF DEATH: Month: 10 Day: 25 Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 20 Nov. 1912
9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY: Lawyer
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: ? Lombard
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): W W II
16. SOCIAL SECURITY NO:
17. INFORMANT: Frances F Lombard Address: Beltsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — over 1 mo.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. Address (Street, city, town or county): Riverdale, Md.
22. DATE SIGNED: 10-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 28, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Gate of Heaven cemetery
23d. LOCATION (City or Town) (County) (State): Wheaton Montgomery Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a. RECD BY REGISTRAR DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14330

CERTIFICATE OF DEATH

14335

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 5506 Shadyside Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

74

3 NAME OF DECEASED (Type or print): First: Mildred — Middle: L. — Last: Long

4 DATE OF DEATH: Month: Oct. — Day: 13 — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Sep.
8 DATE OF BIRTH: 5/18/16
9 AGE (In years last birthday): 51 YRS — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY: AT HOME
11 BIRTHPLACE (County & State, or foreign country): WASH. D.C.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: WILLIAM E. SUMMERS
14. MOTHER'S MAIDEN NAME: KATE V. WATSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): NONE
16 SOCIAL SECURITY NO: 578-10-3886
17. INFORMANT: LEON T. LONG — Address: SAME AS # 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Advanced Cancer of the Cervix with Metastasis
DUE TO
(b) (Heavy Vaginal Bleeding)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/18, 1967, to 10/13, 1967, that (I) (we) last saw the deceased alive on 10/13, 1967, and that death occurred at 3:40P M, from causes and on the date stated above

22a SIGNATURE: F. Kazemi
MD — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 10/13/67
22c. PHYSICIAN'S NAME (Type): FARIZAR KAZEMI
22d ADDRESS: Prince George's General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/17/67
23c NAME OF CEMETERY OR CREMATORY: CEDAR HILL
23d LOCATION (City or Town) (County) (State): SUITLAND, MD.

24. FUNERAL DIRECTOR: W. W. Chambers, Inc.
ADDRESS: 1400 Chapin St. N.W. Wash. D.C. 20009
25a. RECD BY REGISTRAR DATE: OCT 18 1967
25b REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14336

1 PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN (a): DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: RFD 1, Old Montgomery Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Donald Middle: Ernest Last: Lorenz

4 DATE OF DEATH: Month: 10 Day: 18 Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 10-4-1924

9. AGE (In years last birthday): 43 yrs

IF UNDER 1 YEAR: Months: Days:

IF UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINT. MAN

10b KIND OF BUSINESS OR INDUSTRY: BUILDING

11. BIRTHPLACE (State or foreign country): Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALFRED M. LORENZ

14 MOTHER'S MAIDEN NAME: ALICE HANNEL

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes give war or dates of service): WW II

16 SOCIAL SECURITY NO.: 218-12-6741

17 INFORMANT: ELEANORA M. LORENZ Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Hemo-peritoneum
DUE TO Laceration of liver
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Undetermined

20c TIME OF INJURY Month, Day, Year Hour a.m.: 10:45am 10-18 1967

20d INJURY OCCURRED White at work ☐ Not White at work ☒

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): 12705 Cedraville Lane, Laurel, P.G.

20f (City or town) (County) (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.

EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 10-19-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 10/21/67

23c NAME OF CEMETERY OR CREMATORY: ST. JOHN'S LUTHERAN

23d LOCATION (City or Town) (County) (State): HOWARD CO. MD.

24. FUNERAL DIRECTOR: E.S. MACNABB ADDRESS: 301 FREDERICK Rd 21228

25a. REC'D BY REGISTRAR DATE: OCT 23 1967

25b REGISTRAR'S SIGNATURE: [illegible]

VR A15ME (5) 6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14332

CERTIFICATE OF DEATH

14337

1. PLACE OF DEATH
a. COUNTY: Prince George's
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Brandywine
c. LENGTH OF STAY IN 1b: 17 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Brandywine
d. STREET ADDRESS: Rt. 1-Box 394
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Clines Middle: L. Last: Lyles
4. DATE OF DEATH: Month: October Day: 28 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: May 10, 1902
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Newbury, S. Carolina
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Lyles
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lottie Lyles Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Simple Cerebrovascular Accident
DUE TO (c): [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1 D; [illegible]
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-12, 1956, to 10-28, 1967, that (I) (we) last saw the deceased alive on 10-21, 1967, and that death occurred at 8.30 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 4/67
23c. NAME OF CEMETERY OR CREMATORY: St. Thomas Ch. Cemetery
23d. LOCATION (City, town or county) (State): Brandywine, Maryland
24. FUNERAL DIRECTOR: Martell Adams
ADDRESS: Aquasco, Maryland
25a. REC'D BY REGISTRAR: DATE NOV 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20M 1/68

9 — 1
6

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14333 Item 3 Film G393 10/20/67 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14338

1 PLACE OF DEATH
a COUNTY: Prince George's MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland
b COUNTY: Prince George's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Hill
d STREET ADDRESS: 5015 Kirby Hill Road, #404-B
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-1

3 NAME OF DECEASED (Type or print): First: Zebulun / Zebulun Lash; Middle: MacMillan / Macmillan

4 DATE OF DEATH: Month 10 Day 13 Year 19 67

5 SEX: male
6 COLOR OR RACE: white
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3-13-06
9 AGE (In years last birthday): 61 yrs
UNDER 1 YEAR: Months / Days
UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School administrator
10b KIND OF BUSINESS OR INDUSTRY: Prep. School
11 BIRTHPLACE (State or foreign country): New Jersey
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kerr Duncan Macmillan
14 MOTHER'S MAIDEN NAME: Cornelia Lash

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW II (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Wife: Mrs. Jeannette Macmillan, Address: Shenandoah Retrea, Bluemont, V

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Arteriosclerotic Heart Disease — over 3 yrs.
DUE TO (c)
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

410.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus for over 10 years

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe M.D., Address (Street, city, town, or county): Riverdale, Maryland

22 DATE SIGNED: 10-14-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/16/67
23c NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
23d LOCATION (City or Town) (County) (State): Berryville, Clarke, Va.

24 FUNERAL DIRECTOR: JOHN H. ENDERS FUNERAL HOME ADDRESS: Berryville va
Charles J. Enders
25a REC'D BY REGISTRAR DATE: OCT 17 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MSPM. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14339

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6279 64th Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: Marie — Last: Marietta
4. DATE OF DEATH: Month: 10 — Day: 15 — Year: 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7 Nov., 1938
9. AGE (In years last birthday): 28 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PSYCHOLOGY TEACHER
10b. KIND OF BUSINESS OR INDUSTRY: MD. UNIVERSITY
11. BIRTHPLACE (State or foreign country): PENNA
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: VICTOR MARIETTA JR
14. MOTHER'S MAIDEN NAME: MARGARET HAUSMAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT: VICTOR MARIETTA Jr. — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intoxication-barbiturates — 3 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Took overdose of nembutal.
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: unknown 10-13-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Same as #2

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale, Md.
Address (Street, city, town, or county)
22. DATE SIGNED: 10-15-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Oct 19, 1967
23c. NAME OF CEMETERY OR CREMATORY: ST. EDWARDS CEM
23d. LOCATION (City or Town) (County) (State): SHAMOKIN, PENNA.
24. FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: Riverdale, Md
25a. REC'D BY REGISTRAR DATE: OCT 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14335

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14340

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2239 12th St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

74

3 NAME OF DECEASED (Type or print): First: James — Middle: Robert — Last: Marshall
4 DATE OF DEATH: Month: 10 — Day: 20 — Year: 19 67
5 SEX: M
6 COLOR OR RACE: Negro
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 21 Mar., 1942
9 AGE (In years last birthday): 25 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most [redacted] retired)
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12 CITIZEN OF WHAT COUNTRY: USA
13 FATHER'S NAME: James Marshall
14 MOTHER'S MAIDEN NAME: Resetta ?
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: Resetta Marshall — Address

MED CA. CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b): Post surgical, 11days-Laceration of liver
DUE TO
(c): Gunshot wound of abdomen — 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18): Shot following altercation
20c TIME OF INJURY Month, Day, Year Hour a.m.: 10:45 pm 10-9 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street in front of 951 E-W Hightway P.G. Md.
20f (City or town) Takoma Park (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale — Address (Street, city, town, or county)
22. DATE SIGNED: 10-22-67

23a BURIAL, CREMATION, REMOVAL: Burial
23b DATE THEREOF: 10/26/1967
23c NAME OF CEMETERY OR CREMATORY: Harmony
23d LOCATION (City or Town) (County) (State): Landover, Maryland

24 FUNERAL DIRECTOR: W. Ernest Jarvis Co., Inc. — ADDRESS: 1432 You St., N.W.
25a REC'D BY REGISTRAR DATE: OCT 26 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1-1341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3209 Toledo Place, Hyatts., Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 3209 Toledo Place Hyatts., Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick Middle: Thomas Last: Martin
4. DATE OF DEATH: Month: October Day: 5 Year: 1967
5. SEX: M
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 24, 1918
9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed.
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Rutherford County, N. Carol.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas P Martin
14. MOTHER'S MAIDEN NAME: Dovie Scoggins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 267-05-9513
17. INFORMANT: Mrs. Sudia Martin Address: 3209 Toledo Pl. Hyatts. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured Esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO (b): Chronic Cirrhosis — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 5, 1967, to Oct. 5, 1967, that (I) (we) last saw the deceased alive on 9 am, Oct. 5 1967, and that death occurred at 3:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert A. McCormick M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/5/67
22c. PHYSICIAN'S NAME (Type): Robert A. McCormick
22d. ADDRESS: 11161 New Hampshire Ave. Silver Sp., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 8, 1967
23c. NAME OF CEMETERY OR CREMATORY: Baptist Church Cemetery
23d. LOCATION (City, town or county) (State): Manchester Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. S. Myers, Jr., Westminster, Md.
25a. REC'D BY REGISTRAR DATE: OCT 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (10)
15M 7-62

Contacted by Funeral Dir. Mr. Myers

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14237 — 14342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HILCREST HEIGHTS
c. LENGTH OF STAY IN 1b: 6 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2108 KEATING ST HILCREST HTS MD

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HILCREST HEIGHTS
d. STREET ADDRESS: 2108 KEATING ST HILCREST HTS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERNEST Middle MERRICK Last MASON
4. DATE OF DEATH: Month 10 Day 17 Year 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/4/03
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUS DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: DC TRANSIT
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON DC
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: JOHN THOMAS MASON
14. MOTHER'S MAIDEN NAME: MARGARET ELIZABETH HURRIGAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): 1919-1920
16. SOCIAL SECURITY NO.: 578-16-8316
17. INFORMANT: MRS M. MERRITT Address: 2108 KEATING ST HILCREST HGTS MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS
DUE TO (b) METASTATIC BRONCHOGENIC CARCINOMA — 2 YRS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/15, 1967, to 10/17, 1967, that (I) (we) last saw the deceased alive on 10/16 1967, and that death occurred at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Raymond W Turner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/17/67
22c. PHYSICIAN'S NAME (Type): RAYMOND W TURNER
22d. ADDRESS: 2121 PENN AVE NW WASH DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 20-1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: Simon Bros. — ADDRESS: 1611 Good Hope Rd SE Wash DC
25a. REC'D BY REGISTRAR DATE: OCT 20 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14338

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14343

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1100 N. Stafford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: I. — Last: Massing
4. DATE OF DEATH: Month: 10 — Day: 29 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/10/1942
9. AGE (In years last birthday): 25 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): I.B.M.
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Massing
14. MOTHER'S MAIDEN NAME: Ann Phipps
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 232-70-4576
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Hemorrhagic shock
DUE TO (b) Laceration of neck
DUE TO (c) Trauma - auto accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Driver of car involved in collision
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 1:30am p.m. 10-29-19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): St. Rt. 210, Accokeek, Maryland
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D.
Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-30-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/1/1967
23c. NAME OF CEMETERY OR CREMATORY: Huse Mem.Park Cem.
23d. LOCATION (City or Town) (County) (State): Fayettesville, W.Va.

24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc. ADDRESS: Mt.Rainier, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 31 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

14339

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14344

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cottage City
d. STREET ADDRESS: 3708 Bladensburg Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Forest — Middle: Earl — Last: Mathers
4. DATE OF DEATH: Month: Oct. — Day: 5, — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/10/ 1915
9. AGE (In years last birthday): 52 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Sta. Att.
10b. KIND OF BUSINESS OR INDUSTRY: Home Oil Co.
11. BIRTHPLACE (County & State, or foreign country): W.Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harry Mathers
14. MOTHER'S MAIDEN NAME: Flossie Smarr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Ruby P. Mathers (above address) (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Stenosing coronary arteriosclerosis
420 /
DUE TO
(b) Bullous emphysema and severe congestion of lungs bilateral
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the hospital~~) attended the deceased from 9-25, 1967, to Oct.5, 1967, that (I) (~~we~~) last saw the deceased alive on 19, and that death occurred at 10:15 AM, from causes and on the date stated above.

22a. SIGNATURE: George J. Hageage — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): George J. Hageage, M. D.
22d. ADDRESS: 3717 38th Ave. Cottage City, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/8/67
23c. NAME OF CEMETERY OR CREMATORY: Beech Valley Cem.
23d. LOCATION (City or Town) (County) (State): Beech Valley, W.Va.

24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc. — ADDRESS: Mt.Rainier, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 9 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14340

CERTIFICATE OF DEATH

14345

1. PLACE OF DEATH
a. COUNTY: Prince Georges' County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
c. LENGTH OF STAY IN 1b: 2 mos 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pine View Gardens Health Care Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRYANS ROAD
d. STREET ADDRESS: RT 1 BOX 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle J. Last McCARTHY

4. DATE OF DEATH: Month 10 Day 26 Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 5-29-1869
9. AGE (In years lost birthday): 98 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (County & State, or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ANDREW McCARTHY
14. MOTHER'S MAIDEN NAME: ANNA TAYLOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 212-56-0792
17. INFORMANT: MRS. A.R. GUISINGER, BRYANS RD., MD. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARDIO-RESPIRATORY COLLAPSE
1024
DUE TO (b): GENERALISED WEAKNESS
DUE TO (c): SENILITY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY, 1964 to 10-26, 1967 that (I) (we) last saw the deceased alive on 10-26 1967, and that death occurred at 9:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Alfred R. Klapper, M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-26-67
22c. PHYSICIAN'S NAME (Type): ALFRED R. KLAPPER
22d. ADDRESS: CLINTON, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: OCT 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY
23d. LOCATION (City or Town) (County) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR: HUNTT FUNERAL HOME
ADDRESS: WALDORF, MD.
25a. REC'D BY REGISTRAR DATE OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

14341

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14346

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hyattsville Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2853 Ontario Road, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: — Last: Means
4. DATE OF DEATH: Month: October — Day: 3, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 24, 1901
9. AGE (In years last birthday): 66 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service-Clerk (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Gov't.
11. BIRTHPLACE (County & State, or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Escue Means
14. MOTHER'S MAIDEN NAME: Annie Ferguson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 577-07-5517-A
17. INFORMANT: Edward Means - Son — Address: 1020 Thistle Ct. Sunnyvale, Cal.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sarcoma of uterus - recurrent — INTERVAL BETWEEN ONSET AND DEATH: 20 years
DUE TO (b) uremia — 10 days
DUE TO (c)
174 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from _____, 1957, to 10/3, 1967, that (I) (we) last saw the deceased alive on 10/3 1967, and that death occurred at 10 30 AM, from causes and on the date stated above.

22a. SIGNATURE: E H Markwood M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/3/67
22c. PHYSICIAN'S NAME (Type): E H Markwood M.D.
22d. ADDRESS: 3208 - 17 st NW

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/6/67
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia
24. FUNERAL DIRECTOR: C. M. Grauel, Murphy Funeral Home, — ADDRESS: Arlington, Virginia
25a. REC'D BY REGISTRAR: DATE OCT 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14347

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1½ Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6511 Highland Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 6511 Highland Avenue
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Thomas — Last: Medlin
4. DATE OF DEATH: Month: 10 — Day: 25 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 10 July 1924
9. AGE (In years lost birthday): 43 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10b. KIND OF BUSINESS OR INDUSTRY: Pet Shop
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Redford Thomas Medlin
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): Korean
16. SOCIAL SECURITY NO.: 578-38-5927
17. INFORMANT: Mrs. Barbara Medlin — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Occlusion of mouth and nose by plastic bag
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Put plastic bag over head
20c. TIME OF INJURY Month, Day, Year: 11:30am 10-25- 19 67
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): same as #2 (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
Address (Street, city, town, or county)
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22. DATE SIGNED: 10-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 30/1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore Nat'l Cem.
23d. LOCATION (City or Town): Baltimore (County) (State): Md.

24. FUNERAL DIRECTOR: W. W. CHAMBERS CO. — ADDRESS: Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14343

CERTIFICATE OF DEATH

14348

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove (carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Magnolia Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Ranier
d. STREET ADDRESS: 3700 Arundel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: — Last: NASOFF

4. DATE OF DEATH: Month: 10 — Day: 30 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 19, 1902
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Nathan Wilner
14. MOTHER'S MAIDEN NAME: Amelia Kaplan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 052-09-7998
17. INFORMANT: William Nasoff — Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Rheumatic heart disease — 8 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure (chronic)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1966, 19__ to 10/30, 1967, that (I) (we) last saw the deceased alive on 10/29/67 19__, and that death occurred 6:25 AM, from causes and on the date stated above.

22a. SIGNATURE: Leon R. Levitsky M.D. — ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/30/67
22c. PHYSICIAN'S NAME (Type): Leon R. Levitsky, M.D.
22d. ADDRESS: 3408 Rhode Island Avenue, Mt. Ranierm Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-1-1967
23c. NAME OF CEMETERY OR CREMATORY: Geo. Wash. Cemetery
23d. LOCATION (City or Town) (County) (State): Hyattsville, Md.

24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St., N.W.
25a. REC'D BY REGISTRAR DATE: NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

BP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11344

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14349

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1420 University Blvd.

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 1420 University Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Alice — Last: Neele

4. DATE OF DEATH: Month: 10 — Day: 25 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 27 May 1908

9. AGE (In years last birthday): 59 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSE BY
IMMEDIATE CAUSE (a) Inanition
DUE TO (b) Chronic alcoholism
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.

EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 10-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE THEREOF: 10-27-67

23c. NAME OF CEMETERY OR CREMATORY: U of Md. Med. School

23d. LOCATION (City or town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR:
ADDRESS:

25a. REC'D BY REGISTRAR DATE OCT 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

14345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PRINCE GEORGE GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERWYN
d. STREET ADDRESS: 5100 BERWYN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER Middle N. Last NEITZEY SR.
4. DATE OF DEATH: Month OCT. Day 28 Year 19 67
5. SEX: MALE
6. COLOR OR RACE: CAU.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12 March 1890
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED (ELECTRICIAN)
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOV'T
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? US.
13. FATHER'S NAME: THOMAS H. NEITZEY
14. MOTHER'S MAIDEN NAME: VIRGINIA DUTTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 216-09-9245
17. INFORMANT: DOROTHY E. NEITZEY WIFE Address: SAME AS #=2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Failure
DUE TO (b): Arteriosclerotic Coronary
DUE TO (c): Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19 to Oct 28 67, that (I) (we) last saw the deceased alive on Oct 25 1967, and that death occurred at 11 AM, from causes and on the date stated above

22a. SIGNATURE: W L Etienne M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/31/67
22c. PHYSICIAN'S NAME (Type): W.L. ETIENNE
22d. ADDRESS: College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/31/67
23c. NAME OF CEMETERY: [redacted] GEORGE WASHINGTON
23d. LOCATION (City or Town) (County) (State): HYATTSVILLE MD.

24. FUNERAL DIRECTOR: GASCH'S Funeral Home
ADDRESS: HYATTSVILLE, MARYLAND
25a. REC'D BY REGISTRAR DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14346 Reg. Dist. No. 14351

1 PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden
d. STREET ADDRESS 8614 Glenarden Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Joseph Middle Clinton Last Newman
4. DATE OF DEATH Month 10 Day 19 Year 1967
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 9 1888
9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.C. Co'l
10b. KIND OF BUSINESS OR INDUSTRY Labor
11. BIRTHPLACE (State or foreign country) Md.
12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Albert Newman
14 MOTHER'S MAIDEN NAME Parker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.
17 INFORMANT Ella Newman Address Glenarden

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
157 X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/19/55 19 to 10/19/67 19 that I last saw the deceased alive on 10/19/67, and that death occurred at 8:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Henry A. Wise M.D. ADDRESS (Street, city or town, state) 9005 Valt St Lanham Md DATE SIGNED
PHYSICIAN'S NAME (Type) Henry A. Wise Jr. 9005 Valt St Lanham Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-24-67
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
22d LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE ROLLINS FUNERAL HOME, INC. ADDRESS 4339 Hunt Pl Washington, D.C.
24a REC'D BY REGISTRAR DATE OCT 23 1967
24b. REGISTRAR'S SIGNATURE Beverley Jordan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14347

CERTIFICATE OF DEATH

14352

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d. STREET ADDRESS: 3309 Morelane Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emanuel — Middle: Robert — Last: Noel
4. DATE OF DEATH: Month: Oct. — Day: 6 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/20/29
9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronic Engineer
10b. KIND OF BUSINESS OR INDUSTRY: G S A
11. BIRTHPLACE (County & State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Emanuel Richard Noel
14. MOTHER'S MAIDEN NAME: Emily Hand
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 202 20 5445
17. INFORMANT: Devona E Noel — Address: Bowie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): VIRAL ENCEPHALITIS
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 9/3/67, 19__, to Oct. 6, 1967, that (I) (~~we~~) last saw the deceased alive on Oct. 6, 1967, and that death occurred at 5:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Roger B. Ingham M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/6/67
22c. PHYSICIAN'S NAME (Type): Roger Ingham, M.D.
22d. ADDRESS: 5701 85th Ave. Carrollton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 9, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 9 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12349

CERTIFICATE OF DEATH

14353

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON, MARYLAND
c. LENGTH OF STAY IN 1b: 6/30/67 10/2/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PINE VIEW GARDENS HEALTH CARE CENTER

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Ge
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capitol Heights, Maryland
d. STREET ADDRESS: 59th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Isabelle Middle Delia Last North
4 DATE OF DEATH: Month 10- Day 02 Year 1967
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-12-94
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Blackshen Ga.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James George Richard O'Neal
14. MOTHER'S MAIDEN NAME: Smantha Nichols
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 261-18-3973
17. INFORMANT: ALFRED R. LAPIN, Address: CLINTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIO RESPIRATIORY COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Chachexia - Osteo Arthritis — 6 yrs
DUE TO
(c) Arteriosclerotic Cardio Vascular Disease — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1967, to 10-2, 1967 that (I) (we) last saw the deceased alive on 10-2 1967 and that death occurred at 12:25 P.M. from causes and on the date stated above.

22a. SIGNATURE: Alfred R Lapin, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): ALFRED R. LAPIN, MD
22d. ADDRESS: CLINTON, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/7/67
23c. NAME OF CEMETERY OR CREMATORY: North Cemetery
23d. LOCATION (City or Town) (County) (State): Dupont, Georgia

24. FUNERAL DIRECTOR: Robert E. Wilhelm
ADDRESS: 438 Suitland Rd. Suitland Md.
25a. REC'D BY REGISTRAR: DATE OCT 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Item 18 Film 394 11-7-67 am

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1249

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14354

1 PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1721 Addison Rd

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
d. STREET ADDRESS: 1767 Addison Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First REBECCA Middle KAY Last PADGETT

4 DATE OF DEATH: Month Oct. Day 7 Year 1967

5 SEX: F
6 COLOR OR RACE: N
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 12/14/58 Oct 14 1958
9 AGE (In years last birthday): 8 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Annapolis Md
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Lonnie W Padgett
14 MOTHER'S MAIDEN NAME: Virginia Ellen Suppon

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: None
17 INFORMANT: Father Lonnie Padgett Address: 1267 Addison Rd District Hts

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): External strangulation
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
783 X
INTERVAL BETWEEN ONSET AND DEATH: few minutes

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH ☐
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
Found apparently Strangled & Raped

20c TIME OF INJURY: Month Day Year Hour a.m. p.m. Prior to 3 AM Oct 7 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): unknown
20f (City or town) District Heights (County) (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Dayton O Watkins M.D.
EXAMINER'S NAME (Type): DAYTON O WATKINS
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 10-7-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/12/67
23c NAME OF CEMETERY OR CREMATORY: Hillside Memorial Park Cem
23d LOCATION (City or Town) Savannah (County) (State) Ga.

24 FUNERAL DIRECTOR: W.W. Chambers Inc
ADDRESS: 361 - 30 Ave Silver Spring Md
25a RECORDED BY REGISTRAR: DATE OCT 11 1967
25b REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14355

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Regent Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hillcrest Hghts
d. STREET ADDRESS: 18 Colebrook Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: — Last: Papaleo
4. DATE OF DEATH: Month: October — Day: 16 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-28-1900
9. AGE (In years last birthday): 67 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoemaker
10b. KIND OF BUSINESS OR INDUSTRY: Shoe
11. BIRTHPLACE (County & State, or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Vincenzio Papaleo
14. MOTHER'S MAIDEN NAME: Maria DiBlasi
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Catherine Papaleo — Address: 18 Colebrook Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive Heart Failure Pneumonitis
DUE TO
(b): ASHD, HCVD-
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-5, 1967 to 10-16, 1967, that (I) (we) last saw the deceased alive on 10-15 1967, and that death occurred at 12 M. from causes and on the date stated above.

22a. SIGNATURE: John F. Shay — M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): JOHN F. SHAY
22d. ADDRESS: 5509 Old Silver Hill Rd Suitland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/19/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Suitland, Prince Georges, Md

24. FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home — ADDRESS: 4308 Suitland Road, Suitland, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

E. 14356

1 PLACE OF DEATH
a. COUNTY: Prince George MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. b. COUNTY: Prince George
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d STREET ADDRESS: 12013 Tweed Lane,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Ester Middle Lost Paperman
4 DATE OF DEATH: Month 10-13 Day Year 19 67
5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ W DOWED ☒ D VORCED ☐
8 DATE OF BIRTH: 8 Sept 1892
9 AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11 BIRTHPLACE (State or foreign country): PHILA, PA
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: NERMAN ROSEN KRANTZ
14. MOTHER'S MAIDEN NAME: SIMA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17 INFORMANT: SELMA Gottlieb Address: 12013 TWEED LANE, BOWIE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
(b) Arteriosclerotic heart disease — Over 1 yr.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4-1-00

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus-over 30 yrs.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city town, or county)
22. DATE SIGNED: 10-13-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10-15-67
23c NAME OF CEMETERY OR CREMATORY: MT. SHARON CEM
23d. LOCATION (City or Town) (County) (State): SPRINGFIELD DEL. CO. PA.
24. FUNERAL DIRECTOR: Sherman Feldman
ADDRESS: 2317 N. Broad St Phila Pa
25a REC'D BY REGISTRAR DATE OCT 17 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

14352

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14357

1 PLACE OF DEATH a. COUNTY: PRINCE GEORGE'S MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANHAM
c. LENGTH OF STAY IN 1b: 1 MONTH
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MAGNOLIA GARDEN'S NURS. HOME

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: VIRGINIA b. COUNTY: None
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ALEXANDRIA
d. STREET ADDRESS: 117 W. REED AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First MARY Middle N. Last PAPIECK
4. DATE OF DEATH: Month OCT. Day 31 Year 19 67
5. SEX: F
6. COLOR OR RACE: CAU.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: (Unknown) 1876
9. AGE (In years last birthday): 91 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b KIND OF BUSINESS OR INDUSTRY: At Home
11 BIRTHPLACE (County & State, or foreign country): AUSTRIA
12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Steven Nacin
14. MOTHER'S MAIDEN NAME: Rose (Unobtainable)
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 231 70 3019 J
17. INFORMANT: Miss Pauline M. Papieck Address: 117 W. Reed Ave. Alex., Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b) Uremia — 10 days
DUE TO (c) Hypertension — 12 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/29, 19 67 to Oct 31, 19 67 that (I) (we) last saw the deceased alive on 10/3 19 67, and that death occurred at 1:25 P.M. from causes and on the date stated above

22a SIGNATURE: [signature] M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Sean R. Levitsky
22d. ADDRESS: 3408 Rhode Island Ave. MT Rainie

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 4 Nov. 67
23c NAME OF CEMETERY OR CREMATORY: St. Cecilia's Cemetery
23d LOCATION (City or Town) (County) (State): Rockaway, New Jersey
24. FUNERAL DIRECTOR: B. Earle Mountoothe Cunningham Funeral Home ADDRESS: Alex., Va.
25a. REC'D BY REGISTRAR DATE: NOV 2 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14353

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14358

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 16100 Gerald Road extended

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Kensett~~ Silver Springs
d. STREET ADDRESS: 1103 ~~xxxxxx~~ Playford Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Castandinas — Middle: Gus — Last: Pappas Jr.
4. DATE OF DEATH: Month: 10 — Day: 28 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-17-1949
9. AGE (In years last birthday): 18 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: Prince Geo. Jr. Col.
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Costandinas G. Pappas
14. MOTHER'S MAIDEN NAME: Josephine Sprouse
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: yes
17. INFORMANT: 1103 Playford Lane Address — Costandinas G. Pappas — Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:
11-25
IMMEDIATE CAUSE (a) Asphyxia
DUE TO Strnagulation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Crushed by lift mechanism of front end loader.
20c. TIME OF INJURY Month, Day, Year — Hour a.m. 5:15pm p.m. 10-28- 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Same as # 1
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county)
22. DATE SIGNED: 10-30-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 31, 67
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City or Town) (County) (State): Falls Church, Virginia
24. FUNERAL DIRECTOR: C. Glen Carter ADDRESS 8434 Ga. Ave. Wagner C. Pumphrey, Inc. Silver Spring, Md
25a. REC'D BY REGISTRAR DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit; File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

YR A15ME (S)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14354

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14359

1 PLACE OF DEATH
a COUNTY: Prince George's — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Prince George's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights
d STREET ADDRESS: 5322 28th Parkway
e IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: Franklin — Middle: A. — Last: Partin
4 DATE OF DEATH: Month: 10 — Day: 23 — Year: 19 67
5 SEX: male
6 COLOR OR RACE: white
7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: 12-6-14
9 AGE (In years last birthday): 52 ~~XX~~ yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): District of Columbia Employee
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Washington D. C.
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Partin
14 MOTHER'S MAIDEN NAME: Etla V. Neale
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service): WW 11
16 SOCIAL SECURITY NO:
17 INFORMANT: Dorothy A. Partin — Address: Same As # 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
3531
IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b) Grand mal seizure — minutes
DUE TO
(c) Epilepsy — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
22. DATE SIGNED: 10-23-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/26/67
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Prince Georges, Maryland

24 FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home
ADDRESS: 4308 Suitland Road, Suitland, Maryland
25a REC'D BY REGISTRAR DATE: OCT 27 1967
25b REGISTRAR'S SIGNATURE: Charles Yuzge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14356

CERTIFICATE OF DEATH

14361

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Laurel~~ Riverdale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ~~Eugene Leland Memorial Hospital~~

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Maryland
d. STREET ADDRESS: ~~Oaklands Contee Road~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Pecor, Middle: Eugene, Last: Patrick
4. DATE OF DEATH: Month 10, Day 27, Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/30/14
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles A. Pecor
14. MOTHER'S MAIDEN NAME: Helen Murphy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO: 262-44-0691
17. INFORMANT: Mr. H. W. Lady, 4101 Bradley Lane, Address Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO (b) Generalized Arteriosclerosis — Unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 21, 1967 to Oct 27, 1967 that (I) (we) last saw the deceased alive on Oct 27 1967, and that death occurred at 11:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: C. J. Houmann M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Dr. C. J. Houmann
22d. ADDRESS: 4404 Queensbury Rd Riverdale, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-31-1967
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: Wash. DC.
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14355 — 14360

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AFB
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MALCOLM GROW USAF HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POMFRET, MARYLAND
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH — Middle DAVIS — Last PECK
4. DATE OF DEATH: Month OCTOBER — Day 27 — Year 19 67
5. SEX: FEMALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 13 OCTOBER 1889
9. AGE (In years last birthday): 78 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (County & State, or foreign country): ELMIRA, NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: GEORGE L DAVIS
14. MOTHER'S MAIDEN NAME: JULIA ROE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-48-1881
17. INFORMANT: Gen. Dewitt Peck, Address: Pomfret, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs
DUE TO (b): POSSIBLE PULMONARY EMBOLUS OR MYOCARDIAL — 3 Days
DUE TO (c): INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 25 October, 19 67, to 27 Oct, 19 67, that I (we) last saw the deceased alive on 27 October 19 67, and that death occurred at 9:25 P.M., from causes and on the date stated above.

22a. SIGNATURE: Allen D Ward — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☑
22b. DATE SIGNED: 27 Oct 67
22c. PHYSICIAN'S NAME (Type): ALLEN D WARD, MD
22d. ADDRESS: MALCOLM GROW USAF HOSPITAL, ANDREWS AFB, WASH DC 20331

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-31-'67
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat.
23d. LOCATION (City or Town) (County) (State): Arlington, Arlington, Va.
24. FUNERAL DIRECTOR: McHenry Funeral Home
ADDRESS: Waldorf, Md.
25a. REC'D BY REGISTRAR — DATE: NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Yuzge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4353 Item #10a Film #G394 11/6/67 ph

CERTIFICATE OF DEATH

14363

1 PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 4711 67th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Everett Middle: Raymond Last: Peterson
4. DATE OF DEATH Month: October Day: 28 Year: 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH January 31, 1913
9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Retired, Equipment Operator
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (County & State, or foreign country) Houston, Minnesota
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Alvin Peterson
14. MOTHER'S MAIDEN NAME Laura Schuman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO 577-24-4449
17. INFORMANT Ruth A. Peterson Address Hyattsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: A Moment
DUE TO (b) Arteriosclerotic Heart Disease — Many years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4 x 00

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/5, 1965, to 10/28, 1967, that (I) (we) last saw the deceased alive on 10/24 1967, and that death occurred at [illegible] A.M., from causes and on the date stated above

22a. SIGNATURE Frederick Henry Wilhelm M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 10/28/67
22c. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M.D.
22d. ADDRESS [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Oct 3, 1967
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE OCT 31 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

14359 Item #9 Film "G" 11/53/67 ch

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14364

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): University Park
d. STREET ADDRESS: 4200 Van Buren Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: John — Middle: F — Last: Pillsbury

4 DATE OF DEATH: Month: Oct. — Day: 29 — Year: 19 67

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 26 April 1893

9 AGE (In years lost birthday): 74/73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William P. Pillsbury

14. MOTHER'S MAIDEN NAME: Catherine Orem

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 578-14-9241

17 INFORMANT: Ethel Pillsbury-wife — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Obstructive Lung Disease
DUE TO
(b): Chronic Infection of Lungs
DUE TO
(c): Bronchiectasis

327.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 10-12, 19 67, to 10 28, 19 67 that (I) (we) ~~last~~ saw the deceased alive on 10 28 19 67, and that death occurred at 2.00 AM from causes and on the date stated above.

22a SIGNATURE: C. Deitz M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 10 29 67

22c. PHYSICIAN'S NAME (Type): Aaron Deitz M.D.

22d. ADDRESS: Prince Lee Plaza, Hyattsville, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-1-1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d LOCATION (City or town) (County) (State): Colmar Manor, Maryland

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: 300 4th St. NE Wash. DC

25a. REC'D BY REGISTRAR DATE: OCT 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2d Film "3/93 [illegible] Item #11

CERTIFICATE OF DEATH

M 14257 14362

1 PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGES GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, DC
d. STREET ADDRESS Old Silver Hill Road 3504 ~~BRANCH AVE. S.E.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First DR. MATTHEW Middle Last PERSION
4. DATE OF DEATH Month 10 Day 2 Year 1967
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAR. 15, 1898
9. AGE (In years last birthday) 69 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTAL SURGEON
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) WISCONSIN / Russia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MAURICE PERSION
14. MOTHER'S MAIDEN NAME BERTHA KRASNICK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II
16. SOCIAL SECURITY NO
17. INFORMANT WIFE Address MRS. DOROTHY PERSION AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO (b) Coronary Artery Disease — 6 yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anxiety Neurosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from June, 1961, to 10-1, 1967, that (I) (we) last saw the deceased alive on 9-28 1967, and that death occurred at 5:30 AM, from causes and on the date stated above.

22a. SIGNATURE Bernard H. Ostrow M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Bernard H. Ostrow, M.D.
22d. ADDRESS 8107 Eastern Ave., Silver Spring, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 10-4-67
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City or Town) (County) (State) MILWAUKEE, WISCONSIN

24. FUNERAL DIRECTOR Donnavolly & Sons ADDRESS 3501-14th St. NW
25a. REC'D BY REGISTRAR DATE OCT 3 1967
25b. REGISTRAR'S SIGNATURE Jeremiah Judge

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14250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14365

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural (Glenn Dale)
c. LENGTH OF STAY IN 1b: 2 yrs. 26 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1700 Vee Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Erie — Middle: T. — Last: Price
4. DATE OF DEATH: Month: Oct. — Day: 20, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 11, 1907
9. AGE (In years last birthday): 60 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10b. KIND OF BUSINESS OR INDUSTRY: Nursery School
11. BIRTHPLACE (County & State, or foreign country): Louisa County, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Green
14. MOTHER'S MAIDEN NAME: Jane ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): -
16. SOCIAL SECURITY NO: unknown
17. INFORMANT: Person — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: one week
4200
DUE TO
(b) Arteriosclerotic heart disease — years
DUE TO
(c) Generalized arteriosclerosis — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus; rheumatoid arthritis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from # 9/24, 19 65, to 10/20, 19 67, that (I) (we) last saw the deceased alive on 10/20 1967, and that death occurred at 8:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Moe Weiss — M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: Oct. 20, 1967
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 10/26/67
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial
23d. LOCATION (City or Town) (County) (State): Park Landover Md.

24. FUNERAL DIRECTOR: Johnson & Jenkins — ADDRESS: 4804 Ga. Ave. N.W.
25a. REC'D BY REGISTRAR — DATE: OCT 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Juggs

VR A15 (R) 25M 1/67

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-143. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15UE (5)
6M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14261

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 14368

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper ~~Marlboro~~ Marlboro
d. STREET ADDRESS: RFD Box 3764
e. S RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Adrian — Last: Proctor

4. DATE OF DEATH: Month: 10 — Day: 26 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 30 April 1894
9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov. emp.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Prince Georges, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sylvester Proctor
14. MOTHER'S MAIDEN NAME: Mary Ann Proctor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary M. Proctor — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — over 2 yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):

22. DATE SIGNED: 10-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-31-67
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem.
23d. LOCATION (City or Town) (County) (State): Clinton Pr. Geo. Md.

24. FUNERAL DIRECTOR: Martell Adams — ADDRESS: Aquasco, Md.
25a. REC'D BY REGISTRAR: DATE NOV 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14362 — 14362

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 1/2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
d. STREET ADDRESS: 4804 O Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Marian — Middle: L — Last: Ransom

4. DATE OF DEATH: Month: Oct. — Day: 5 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8. 15. 1914
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (County & State, or foreign country): D C.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Harry D.Poole
14. MOTHER'S MAIDEN NAME: Amelia Able

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clarence G.Ransom — Address: 4804.O st S E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage, massive
434
DUE TO (b): Thrombosis of pons and cerebellum
DUE TO (c): Hypertensive heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(Hospital)~~ attended the deceased from 10 - 4 -, 1967, to Oct. 5, 1967, that (I) ~~HAS~~ last saw the deceased alive on Oct. 5, 1967, and that death occurred at 5:30 AM/PM from the causes and on the date stated above.

22a. SIGNATURE: Oliver B Bond. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10 - 6 - 67
22c. PHYSICIAN'S NAME (Type): Oliver Bond, M. D.
22d. ADDRESS: 6872 Riverdale Rd. Lanham, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10.9.67
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City, town or county) (State): Suitland. Maryland

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: 300 Ft Stanton
25a. REC'D BY REGISTRAR: DATE OCT 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

1

14368

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14368

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Prince George. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs. Md.
c. LENGTH OF STAY IN 1b: 8 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Andrews AFB.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake Beach.
d. STREET ADDRESS: Star Rt I Box 668
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Olaf Middle: E. Last: Rasmussen
4 DATE OF DEATH: Month: 28 Oct Day: Year: 1967

5 SEX: Male
6 COLOR OR RACE: Cauc.
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 28 Nov 1916
9 AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10b KIND OF BUSINESS OR INDUSTRY: USAF
11 BIRTHPLACE (County & State, or foreign country): Bronx, N.Y.
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Rasmus Rasmussen
14 MOTHER'S MAIDEN NAME: Annie Warner

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 1932-1966
16 SOCIAL SECURITY NO: 111-10-8714
17 INFORMANT: June Rasmussen Address: Star Rt Box 668 Chesapeake Beach, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Renal Insufficiency
DUE TO
(b) Hepatic Insufficiency
DUE TO
(c) Chronic Hepatic Cirrhosis

5210

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 20 Oct., 1967 to 27 Oct., 1967 that (II) (we) last saw the deceased alive on 27 Oct., 1967, and that death occurred at 8:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: Ira A. Gould M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☑
22b. DATE SIGNED: 24 Oct '67
22c. PHYSICIAN'S NAME (Type): IRA A. GOULD, MD
22d. ADDRESS: MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH DC 20331

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-1-67
23c NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
23d LOCATION (City or Town) (County) (State): Arlington Va.

24 FUNERAL DIRECTOR: Hutchins Funeral Home
ADDRESS: Owings Md.
25a. REC'D BY REGISTRAR DATE: NOV 2 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Items 18&21 Film 396
12-22-67 ams

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14369

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN Hospital: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 41 B Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: Lorraine; Middle: Elvira; Last: Redden
4 DATE OF DEATH: Month: 10; Day: 23; Year: 19 67
5 SEX: female
6 COLOR OR RACE: white
7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: 10-22-20
9 AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): waitress
10b KIND OF BUSINESS OR INDUSTRY: restaurant
11 BIRTHPLACE (State or foreign country): Washington DC.
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Oliver Thomas Redden
14 MOTHER'S MAIDEN NAME: Mary Jane Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-12-3026
17 INFORMANT: Hazel DeWitt Address: Seat Pleasant Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocarditis and pericarditis — INTERVAL BETWEEN ONSET AND DEATH
431X
DUE TO
(b) Organism undetermined
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
22. DATE SIGNED: 10-23-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/26/67
23c NAME OF CEMETERY OR CREMATORY: Savage Cemetery
23d LOCATION (City or Town) (County) (State): Savage Md.
24. FUNERAL DIRECTOR: DeWitt Donaldson Laurel Md
ADDRESS
25a RECD BY REGISTRAR DATE: OCT 30 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14365 Item 2 See birth cert. ams

CERTIFICATE OF DEATH

14370

1 PLACE OF DEATH a. COUNTY: PRINCE GEORGE'S — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE

c. LENGTH OF STAY IN 1b: 1 DAY

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF HOSPITAL ANDREWS

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND b. COUNTY: PRINCE GEORGE'S

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~ANDREWS AIR FORCE BASE~~ Indian Head

d. STREET ADDRESS: ~~USAF HOSPITAL ANDREWS~~ Riverview Village

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CASEY — Middle MARIE — Last REED

4 DATE OF DEATH: Month OCTOBER — Day 7 — Year 1967

5 SEX: FEMALE

6 COLOR OR RACE: CAUCASIAN

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 6 OCT 67

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b KIND OF BUSINESS OR INDUSTRY: N/A

11 BIRTHPLACE (County & State, or foreign country): PRINCE GEORGE'S, MD.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CURTIS LYNN REED

14 MOTHER'S MAIDEN NAME: KATHLEEN JOYCE ESSICK (*) REED, MD.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)

16. SOCIAL SECURITY NO: N/A

17 INFORMANT: KATHLEEN J. REED-MOTHER, Address 28A RIVER VIEW VILLIAGE, INDIAN (*)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Respiratory and Cardiac Arrest

DUE TO (b) Respiratory Distress Syndrome

DUE TO (c) Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 30 HRS.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 6 OCT, 1967, to 7 OCT, 1967, that (I) ~~(we)~~ last saw the deceased alive on 7 OCT 1967, and that death occurred at 5:21 PM, from causes and on the date stated above

22a SIGNATURE: Herrick J. Cohen M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☑

22b DATE SIGNED: 7 OCT 67

22c. PHYSICIAN'S NAME (Type): HERRICK J. COHEN

22d. ADDRESS: 4168 SUITLAND RD, SUITLAND, MD 20023

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10/11/67

23c NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEMETERY

23d LOCATION (City or Town) (County) (State): ARLINGTON, VIRGINIA

24 FUNERAL DIRECTOR: ROBERT E. WILHELM FUNERAL HOME — ADDRESS: 4308 SUITLAND ROAD, SUITLAND, MARYLAND

25a REC'D BY REGISTRAR DATE: OCT 11 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14365

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14371

1. PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5104 41st. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adelaide Middle: Carinna Last: Reeside
4. DATE OF DEATH: Month 10 Day 28 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10 July 1882
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Anderson C Quisenberry
14. MOTHER'S MAIDEN NAME: Corinna B Broomhall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: John B Reeside Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe, M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 10-30-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Arlington Va.
24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14367 — 14372

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AF BASE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) — a. STATE: GEORGIA — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDEN
d. STREET ADDRESS: GENERAL DELIVERY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ENOCH — Middle: NMN — Last: REID, JR
4. DATE OF DEATH: Month: OCT — Day: 16 — Year: 1967
5. SEX: MALE
6. COLOR OR RACE: NEGROE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 22 FEB 1919
9. AGE (In years last birthday): 48 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): US ARMY
10b. KIND OF BUSINESS OR INDUSTRY: US ARMY
11. BIRTHPLACE (County & State, or foreign country): ABBEVILLE, GEORGIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ENOCH REID
14. MOTHER'S MAIDEN NAME: NANCY FULLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 258-12-6060
17. INFORMANT: WIFE — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
4 hrs
~~DUE TO~~
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) DIABETES MELLITUS
~~DUE TO~~
(c) CANCER OF LUNG WITH METASTASIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from 16 Oct, 1967, to 16 Oct, 1967 that ~~(I)~~ (we) last saw the deceased alive on 16 Oct 67 19__, and that death occurred at 9:45 AM from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒ — AM
22b. DATE SIGNED: 16 Oct 67
22c. PHYSICIAN'S NAME (Type): ROBERT S. NELSON, CAPT, USAF MC
22d. ADDRESS: USAF Hospital Andrews, Andrews AFB, Wash DC 20331

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 10/18/67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Savannah, Ga.

24. FUNERAL DIRECTOR: Lowe's Funeral Home — ADDRESS: 1425 Md, Ave, N. E. Wash.D. C.
25a. REC'D BY REGISTRAR: DATE OCT 19 1967
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4) 25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14269 14373

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Prince George's Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 19½ mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hyattsville Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: Springvalle Terrace 8805 Springvalle Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle Last Roth
4. DATE OF DEATH: Month OCT. Day 17 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/16/1887
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gvt. worker
10b. KIND OF BUSINESS OR INDUSTRY: WAR DEPT.
11. BIRTHPLACE (County & State, or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN A. ROTH
14. MOTHER'S MAIDEN NAME: MAGGIE HUBNER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-36-1270
17. INFORMANT: ANNA MYERS Address: ALEX., VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST — INTERVAL BETWEEN ONSET AND DEATH: MINS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) CEREBRAL VASCULAR ACCIDENT — 1 MONTH
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS — YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PNEUMONIA; HERPES ZOSTER
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March 9, 1966, to October 17, 1967, that (I) (~~we~~) last saw the deceased alive on October 16 1967, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Harold W. Draper M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/17/67
22c. PHYSICIAN'S NAME (Type): HAROLD W. DRAPER M.D.
22d. ADDRESS: 911 Silver Spring Ave, Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/20/1967
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Congressional
23d. LOCATION (City, town or county) (State): Washington, D.C.
24. FUNERAL DIRECTOR: JAMES T. RYAN, INC. ADDRESS: 317 PA AVE SE DC 3
25a. REC'D BY REGISTRAR DATE: OCT 20 1967
25b. REGISTRAR'S SIGNATURE

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1369 — 14374

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9507 Wire Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: — Last: Saidman
4. DATE OF DEATH: Month 10 — Day 15 — Year 19 67
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10 Dec., 1899
9. AGE (In years on last birthday): 67 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Haberdashery
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob Saidman
14. MOTHER'S MAIDEN NAME: Pearl Stein
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO: 579-14-1730
17. INFORMANT: Arnold Saidman — Address: 3908 Conifer Lane, Bowie, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
+ 2 00
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — over 1 yr.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 10-15-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-17-67
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City or Town) (County) (State): Falls Church Va.
24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St., N.W.
25a. REC'D BY REG STRAR: OCT 20 1967
25b. REG STRAR'S SIGNATURE: J. Charles Judge

1

143-0

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14375

M

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SUITLAND
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4419 WHITEHALL STREET

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MARYLAND — b COUNTY: PRINCE GEORGES
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SUITLAND
d. STREET ADDRESS: 4419 WHITEHALL STREET
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ALBERT Middle FREDERICK Last SCHAUB
4 DATE OF DEATH: Month OCTOBER Day 22 Year 19 67
5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: OCTOBER 23, 1884
9 AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINEST
10b KIND OF BUSINESS OR INDUSTRY: U. S. GOVERNMENT
11 BIRTHPLACE (County & State, or foreign country): WASHINGTON D. C.
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: HERMAN SCHAUB
14 MOTHER'S MAIDEN NAME: WHILEAMINE FREDARICKER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: MELVIN E. SCHAUB — Address: 4411 WHITEHALL ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Feb 4, 1946, to Oct. 22, 1967, that (I) (~~we~~) last saw the deceased alive on 10/21/1967, and that death occurred at 12:34 p M, from causes and on the date stated above.

22a SIGNATURE: Frank S. Pellegrini — MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 10/22/67
22c. PHYSICIAN'S NAME (Type): FRANK S. PELLEGRINI
22d. ADDRESS: 3611 BRANCH AVE SE 20031

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/25/67
23c NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
23d LOCATION (City or Town) (County) (State): PRINCE GEORGES, MARYLAND
24. FUNERAL DIRECTOR: ROBERT E. WILHELM FUNERAL HOME — ADDRESS: 4308 SUITLAND ROAD, SUITLAND, MARYLAND
25a REC'D BY REGISTRAR DATE: OCT 24 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

Item 18 Film 399 - 4/23/68 U.S.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14371

CERTIFICATE OF DEATH

14376

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 12903 Bowie Road Rt 101

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 12903 Bowie Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle EMMA Last SCHIMPF
4. DATE OF DEATH: Month Oct Day 1 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 28, 1873
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic compositor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Tupelo Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN Hall
14. MOTHER'S MAIDEN NAME: EMMA OSIER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-01-8889
17. INFORMANT: Wm J. Schimpf Address 12903 Bowie Rd Laurel Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular — INTERVAL BETWEEN ONSET AND DEATH: 4 1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Disease — ?
DUE TO
(c) Pulmonary Tuberculosis, arrested — 2 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-18, 1967, to 10-1, 1967, that (I) (we) last saw the deceased alive on 10-1 1967, and that death occurred at 2:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Rolando V. Goco M.D.
M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-1-67
22c. PHYSICIAN'S NAME (Type): Rolando V. Goco, M.D.
22d. ADDRESS: 704 Gorman Ave, Laurel, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-4-67
23c. NAME OF CEMETERY OR CREMATORY: OAKWOOD CEMETERY
23d. LOCATION (City or Town) (County) (State): FALLS CHURCH VA

24. FUNERAL DIRECTOR: PEARSON FUNERAL HOME
ADDRESS: FALLS CHURCH VA.
25a. REC'D BY REGISTRAR DATE OCT 4 1967
25b. REGISTRAR'S SIGNATURE: Charles O [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4372

CERTIFICATE OF DEATH

1-13777

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN Hospital: 2yrs.78days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5033 Call Place S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Loretta — Middle: — Last: Scroggins
4. DATE OF DEATH: Month: October — Day: 9 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/6/83
9. AGE (In years last birthday): 83 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (County & State or foreign country): Nassau, Bahama Island
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jerry Ricardo
14. MOTHER'S MAIDEN NAME: Mary Bascade
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: (Decedent) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b) Recurrent cerebrovascular accident — unknown
DUE TO (c) Generalized arteriosclerosis — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 7-23, 1965, to 10-9, 1967, that I (we) last saw the deceased alive on 10-9 19 67, and that death occurred at 12:15PM, from causes and on the date stated above.

22a. SIGNATURE: Moe Weiss — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10-9-67
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/13/67
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Mem.
23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: Robert G. McGuire — ADDRESS: McGuire Funeral Service, 1820-9-N.W.
25a. REC'D BY REGISTRAR DATE: OCT 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4373

CERTIFICATE OF DEATH

1-1378

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural (Glenn Dale)
c. LENGTH OF STAY IN 1b: 11 mo.22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 406 M. Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Rebecca — Middle: - — Last: Seabrook
4. DATE OF DEATH: Month: Oct. — Day: 20 — Year: 19 67
5 SEX: Female
6 COLOR OR RACE: Negro
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 4,1914
9 AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: -
11 BIRTHPLACE (County & State, or foreign country): South Carolina
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: Daniel Stokes
14 MOTHER'S MAIDEN NAME: Rena ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): -
16 SOCIAL SECURITY NO.: unknown
17 INFORMANT: Information from D.C. General Hospital — Address: Washington, D.C.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Possible pulmonary embolism (clinical) — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b)
DUE TO
(c) Generalized arteriosclerosis — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
+500
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral blindness due to optic atrophy; chronic brain syndrome
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 28, 19 66, to Oct 20, 19 67 that (I) (we) last saw the deceased alive on Oct 20 19 67, and that death occurred at 6:15 P.M. M, from causes and on the date stated above.

22a SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b DATE SIGNED: Oct. 20,1967
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10-28-67
23c NAME OF CEMETERY OR CREMATORY: Lincoln Memorial
23d LOCATION (City or Town) (County) (State): Suitland, Md.
24 FUNERAL DIRECTOR: Frazier Funeral Home Inc. — ADDRESS: 389 R.I. Ave. N.W.
25a REC'D BY REGISTRAR: DATE OCT 25 1967
25b REGISTRAR'S SIGNATURE: Mildred Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14374 — 14379

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN Hospital: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6815 Riverdale Road
e. IS RESIDENCE ON A FARM? YES [ ] NO [x]

3 NAME OF DECEASED (Type or print): First: Hazel — Middle: A. — Last: Sechez
4 DATE OF DEATH: Month: 10 — Day: 29 — Year: 19 67
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [x]
8 DATE OF BIRTH: 8-24-27
9 AGE (In years last birthday): 40 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales woman
10b KIND OF BUSINESS OR INDUSTRY: Real Estate
11 BIRTHPLACE (State or foreign country): Maine
12 CITIZEN OF WHAT COUNTRY? U S A
13 FATHER'S NAME: Forrest Baker
14 MOTHER'S MAIDEN NAME: Unknown
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT: Hospital records — Address: Cheverly Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun shot wound of head
Y / 6 X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [x]

20a EXTERNAL CAUSE WAS PRIMARY [x] or CONTRIBUTING [ ] CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Shot self in head.
20c TIME OF INJURY Month Day, Year Hour a.m. p.m.: 1:00 am — 10-22- 19 67
20d INJURY OCCURRED While at work [ ] Not While at work [x]
20e PLACE OF INJURY (Home, farm factory, street, office bldg. etc.): home
20f (City or town) (County) (State): same as #2

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [x], Inquiry [x], and in my opinion death resulted from Natural causes [ ], Accident [ ], Suicide [x], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D. Riverdale, Md.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [x]
Address (Street, city, town, or county)
22. DATE SIGNED: 10-30-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 31, 1967
23c NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14375 Item #15 Film #G394 11/13/67 ph

CERTIFICATE OF DEATH

14380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 25M 1/67

1 PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Magnolia Gardens Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale, Md. 16-1
d. STREET ADDRESS: 5400 54th avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Franz Middle J Last Seiders

4 DATE OF DEATH: Month Oct Day 10, Year 19 67

5 SEX: male
6 COLOR OR RACE: white
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Jan 19, 1904
9 AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired electrician
10b KIND OF BUSINESS OR INDUSTRY: U S Government
11 BIRTHPLACE (County & State, or foreign country): Maine
12 CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Harold L Seiders
14 MOTHER'S MAIDEN NAME: Elizabeth Lane

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) yes no (If yes-give war or dates of service) U.S. Navy 6/19/19 to 9/2 21
16 SOCIAL SECURITY NO
17 INFORMANT: Rose I Seiders Address: East Riverdale, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Metastatic Ca of brain — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
DUE TO (b) Bronchogenic Ca of left bronchus — 6 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

1621

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 3, 1967, to 10-10, 1967 that (I) (we) last saw the deceased alive on 10-10 1967, and that death occurred at 3 30 p M, from causes and on the date stated above

22a SIGNATURE: George Hageage M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 10-11-67
22c PHYSICIAN'S NAME (Type): George Hageage
22d ADDRESS: Cottage City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 14, 1967
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Suitland Pro Georges Md.

24 FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a REC'D BY REGISTRAR DATE OCT 16 1967
25b REGISTRAR'S SIGNATURE: Florence Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15275 14381

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges General Hospital
e. STREET ADDRESS: 7904 Regational Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Carrollton
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD Middle EDWARD Last SEMERJIAN
4. DATE OF DEATH: Month OCTOBER Day 23 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 22, 1913
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman
10b. KIND OF BUSINESS OR INDUSTRY: C.E.Co
11. BIRTHPLACE (County & State, or foreign country): Akron Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ralph Semerjian
14. MOTHER'S MAIDEN NAME: Esther Boyan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Marian Semerjian — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ASCVD
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 1 mo — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1967
20d. INJURY OCCURRED White at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1963 to Oct 23, 1967, that (I) (we) last saw the deceased alive on 9/28 1967, and that death occurred at 10.15 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/24/67
22c. PHYSICIAN'S NAME (Type): Marvin Schneider, M.D.
22d. ADDRESS: 911 Silver Spring Avenue, S.S., MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/27/1967
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Colmar Manor Md.

24. FUNERAL DIRECTOR: J. Arthur Walters
ADDRESS: 254 Carroll St. N.W. Washington, D.C. 20012
25a. REC'D BY REGISTRAR: DATE OCT 26 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner Notified & Reported

VR A15 (4)
2DM 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14371 — 14382

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): SUITLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUITLAND NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DISTRICT HEIGHTS
d. STREET ADDRESS: 7915 FOSTER STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVELYN — Middle K. — Last SERCOMBE
4. DATE OF DEATH: Month 10 — Day 7 — Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JAN. 1, 1879
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): CALIFORNIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MARTIN TRESIDDER
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: FRED W. TRESIDDER — Address: SAME AS # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — Arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH: 8-9 yr.
443X
DUE TO (b) Illness.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/15/59, 19__, to 10/7/67, 19__, that (I) (we) last saw the deceased alive on 10/6/67, 19__, and that death occurred at 6:00 AM, from causes and on the date stated above.

22a. SIGNATURE: William C. Lambert — MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/7/67
22c. PHYSICIAN'S NAME (Type): WILLIAM C. LAMBERT
22d. ADDRESS: 2932 - W ST., S.E. DC. 20

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/10/67
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON CEMETERY
23d. LOCATION (City or Town) (County) (State): UPPER DARBY, PENNSYLVANIA

24. FUNERAL DIRECTOR: ROBERT E. WILHELM FUNERAL HOME — ADDRESS: 4308 SUITLAND ROAD, SUITLAND, MARYLAND
25a. REC'D BY REGISTRAR — DATE: OCT 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14378 14383

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Pringe Geo. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt.Rainier
c. LENGTH OF STAY IN 1b: 12 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3202 - Perry St.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr.Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt.Rainier
d. STREET ADDRESS: 3202 - Perry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wharton Middle B. Shackelford
4. DATE OF DEATH: Month Oct. Day 9 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/25/1889
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Shackelford
14. MOTHER'S MAIDEN NAME: Mary Wallace
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 578-01-2143A
17. INFORMANT: Mrs.Mabel H. Shackelford (above (Wife) address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
DUE TO
(b) Hypertensive Arterio-sclerotic Heart Disease — 10 years.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 1957 to 10/9 1967 that (I) (we) last saw the deceased alive on 10/9 1967, and that death occurred at 11:45 A M, from causes and on the date stated above.

22a. SIGNATURE: Charles C. Hageage M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Charles C. Hageage, M.D.
22d. ADDRESS: 3308 Perry St. Mt. Rainier, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/11/67
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.
23d. LOCATION (City or Town) (County) (State): Colmar Manor, Md.
24. FUNERAL DIRECTOR: Nalley's Funerl Home Inc. ADDRESS: Mt. Rainier, Maryland
25a. REC'D BY REGISTRAR: OCT 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14379 — 14384

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Miss. — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hattiesburg 61
d. STREET ADDRESS: 104 5th St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Davis — Last: Sharp

4. DATE OF DEATH: Month: 10 — Day: 22 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 Feb., 1945

9. AGE (In years last birthday): 22 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cadet

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Naval Academy

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lawler D. Sharp

14. MOTHER'S MAIDEN NAME: Elizabeth Busby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): At time of Death

16. SOCIAL SECURITY NO: 428-88-5528

17. INFORMANT: USNaval Hospital, Bethesda, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Laceration of brain — INTERVAL BETWEEN ONSET AND DEATH
7234
DUE TO (b): Trauma-auto accident — Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Driver of car which collided with a sign.

20c. TIME OF INJURY: Hour 2:40 a.m. p.m. — Month, Day, Year: 10 22 19 67

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Rt 450 nr Central Ave., P.G. — (City or town) — (County) — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale, Md. — Address (Street, city, town, or county)

22. DATE SIGNED: 10-22-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 10/24/67

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City or Town) (County) (State): Hattiesburg, Mississippi

24. FUNERAL DIRECTOR: Milton Taylor — ADDRESS: Falls Church Funeral Home, Falls Church, Va.

25a. REC'D BY REGISTRAR: OCT 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Junger

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14380 **CERTIFICATE OF DEATH** 14385

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Home, 5805 Queens Chapel Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5700 Queens Chapel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma; Middle: P.; Last: Sheehy
4. DATE OF DEATH: Month: October; Day: 28; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 6, 1873
9. AGE (In years last birthday): 94 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Archibald Hutton
14. MOTHER'S MAIDEN NAME: Ella Mitchell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 215-52-9266
17. INFORMANT: Address: Sacred Heart Home, Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): General Bed arteriosclerosis with
DUE TO (c): renal failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 5 years / 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1949, to 10-28, 1967, that (I) (we) last saw the deceased alive on 10-27 1967, and that death occurred at 2 A.M., from causes and on the date stated above

22a. SIGNATURE: Ronald S. Fleischer M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-28-67
22c. PHYSICIAN'S NAME (Type): RONALD S. FLEISCHER
22d. ADDRESS: 7411 RIGGS RD, HYATTSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington D. C.
24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE OCT 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND [redacted] OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14386

1. PLACE OF DEATH
a. COUNTY: Prince George's County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: P.G. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham, Md.
d. STREET ADDRESS: 7600-Fontain Blu Carrolton Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (Ferneda) First: Neda; Middle:; Last: ~~Short~~ Shortt
4. DATE OF DEATH: Month: Oct.; Day: 6; Year: 1967
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-9-03
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert Childus
14. MOTHER'S MAIDEN NAME: Martha Furitt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 279 24 4211
17. INFORMANT: Harold Shortt-son Address: Hyatts, Md. 3617 Gallatin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE — 1 yr.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 5, 19 67, to Oct. 6, 19 67, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. N. Sugar M.D. ADDRESS (Street, city or town, state): 4637 EASTERN AVE., WASH., D.C. 20018 DATE SIGNED: Oct. 6, 1967

PHYSICIAN'S NAME (Type): SAMUEL J.N. SUGAR, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-10-67
22c. NAME OF CEMETERY OR CREMATORY: Woodside Cemetery
22d. LOCATION (City, town or county) (State): Middletown, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home ADDRESS: 500-4th St. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR DATE: OCT 19 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM 5. Form PM 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14388 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 14387

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Clinton
c. LENGTH OF STAY IN 1b: Driving Thru
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Rt. 5, nr Surrats Rd.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 401 11 th St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Cheryll — Middle: Lee — Last: Smalls
4 DATE OF DEATH: Month: 10 — Day: 14 — Year: 1967

5 SEX: F
6. COLOR OR RACE: Negro
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 27 Dec., 1958
9 AGE (In years last birthday): 8 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): WASHINGTON, D. C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rev. Albert O. Smalls
14 MOTHER'S MAIDEN NAME: Mrs. Mattie Hicks

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None — (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: None
17 INFORMANT: Albert D. Smalls — Address: 401 11th Street, S. E.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Burns- 100% of body surface — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Passenger of car involved in collision.
20c TIME OF INJURY Month, Day, Year: Hour a.m. 8:20 pm 8 14 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): St. Rt. 5
20f (City or town): Clinton — (County): P.G. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale — Address (Street, city, town or county)
22. DATE SIGNED: 10-15-67

23a BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF: 10-19-67
23c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEMORIAL CEMETERY
23d LOCATION (City or Town) (County) (State): SUITLAND, MARYLAND

24 FUNERAL DIRECTOR: JOHN T. RHINES FUNERAL HOME — ADDRESS: 3015 12TH ST. N.E. WASHINGTON, D. C.
25a REC'D BY REGISTRAR: DATE OCT 19 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2283 1-1388

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DISTRICT HEIGHTS
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7206 ELMHURST STREET

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DISTRICT HEIGHTS
d. STREET ADDRESS: 7206 ELMHURST STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul Middle: Oster Last: Smeltzer
4. DATE OF DEATH: Month: 10 Day: 24 Year: 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 13, 1915
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: D.C. GOVERNMENT
11. BIRTHPLACE (County & State, or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: HERBERT SMELTZER
14. MOTHER'S MAIDEN NAME: NELLIE OSTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: PHYLLIS B. SMELTZER Address: SAME AS # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

MEDICAL CERTIFICATION

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Coronary Artery Disease — 15 mo.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/1, 1967 to 10/23, 1967, that (I) (we) last saw the deceased alive on 10/23 1967, and that death occurred at 24 M, from the causes and on the date stated above.

22a. SIGNATURE: Frank J. Talbot M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/24/67
22c. PHYSICIAN'S NAME (Type): Frank J. Talbot MD
22d. ADDRESS: 4273 Branch Ave Marlow Heights Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/27/67
23c. NAME OF CEMETERY OR CREMATORY: OSTERBURG REFORMED CEMETERY
23d. LOCATION (City, town or county) (State): OSTERBURG, PENNA.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND
25a. REC'D BY REGISTRAR DATE: OCT 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Yuzzi

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14384 14389

1 PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVER DALE, MD
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel
d. STREET ADDRESS 1600 Washington Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

73

3. NAME OF DECEASED (Type or print) First: Smith Middle: Harry Last: J.
4. DATE OF DEATH Month: October Day: 27 Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1885
9. AGE (in years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NIGHT WATCHMAN
10b. KIND OF BUSINESS OR INDUSTRY: MAYLOR APT.'S
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO: 577-22-0856A
17. INFORMANT: Smith, David 1600 Washington Blvd. Address: Laurel, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMBOLISM — INTERVAL BETWEEN ONSET AND DEATH: ONE DAY
DUE TO (b) ACUTE THROMBOPHLEBITIS — 2 WKS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY, 1967, to 27 OCT, 1967, that (I) (we) last saw the deceased alive on 27 OCT 1967, and that death occurred at 1040 PM, from causes and on the date stated above

22a. SIGNATURE C. J. Houmann M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 10-27-67
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN
22d. ADDRESS RIVERDALE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 10-31-67
23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem.
23d. LOCATION (City or Town) (County) (State) Suitland Md
24. FUNERAL DIRECTOR W. L. Chambers Jr. ADDRESS Riverdale Md
25a. REC'D BY REGISTRAR DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

12 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

14385

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14390

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 5409 Riverdale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: Howard — Last: Smith
4. DATE OF DEATH: Month: Oct — Day: 13, — Year: 19 67
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-2-09
9. AGE (In years last birthday): 58 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical contractor
10b. KIND OF BUSINESS OR INDUSTRY: self
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Oliver C. Smith
14. MOTHER'S MAIDEN NAME: Hazel C Parrish
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service)
16. SOC. SECURITY NO: 380 03 0182
17. INFORMANT: Catherone H Smith — Address: Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) liver failure
DUE TO
(b) Cirrhosis of liver
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland
Address (Street, city, town, or county)
22. DATE SIGNED: 10-14-67

23a. BURIAL, CREMATION, REMOVAL, OTHER: Entombment
23b. DATE THEREOF: Oct 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City or town) (County) (State): Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons Hyattsville, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE OCT 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15285 — 14391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Hyattsville Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince George
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 1513 Jonathon St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lillian Middle: K Last: SMITH
4. DATE OF DEATH: Month: Oct. Day: 12 Year: 19 67
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/29/86
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady-Lansburgh's Dept. Store
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H. Smith
14. MOTHER'S MAIDEN NAME: Lena Rechweig
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 577-01-6973
17. INFORMANT: Andrew H. Smith- Address: 1515 Jonathon St. Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma, breast with
DUE TO (b) generalized metastases.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 15 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 22, 1964, to Oct 12, 1967, that (I) (we) last saw the deceased alive on Oct 10 1967, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William F. Simpson, M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/12/67.
22c. PHYSICIAN'S NAME (Type): William F. Simpson, MD
22d. ADDRESS: 6216 Nilt. Ave NE.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 10/14/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Suitland, Md.
24. FUNERAL DIRECTOR: The S.H. Hines Company ADDRESS: 2901 14th St. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR DATE: OCT 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

5387 — 14392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN (b): 8Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Goergoe General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham, Md.
d. STREET ADDRESS: 7608 Foutianblue Dr.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Daniel — Last: Smith
4. DATE OF DEATH: Month: Oct — Day: 28 — Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Sept 14, 1915
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Tobacco co
11. BIRTHPLACE (County & State, or foreign country): Wicomico County Md
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: walter L Smith
14. MOTHER'S MAIDEN NAME: Mattie Parsons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): W W II
16. SOCIAL SECURITY NO: 214 10 9013
17. INFORMANT: Mrs Mattie Smith — Address: Pittsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4-91X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-28, 1967 to 10-28, 1967 That (I) (we) last saw the deceased alive on 10-28 1967 and that death occurred at 5 p.m., from causes and on the date stated above.

22a. SIGNATURE: John Kehoe — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-28-67
22c. PHYSICIAN'S NAME (Type): JOHN KEHOE
22d. ADDRESS: 6300 Riverdale Rd. Riverdale Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-31-1967
23c. NAME OF CEMETERY OR CREMATORY: Grace Cemetery
23d. LOCATION (City or Town) (County) (State): Pittsville, Maryland
24. FUNERAL DIRECTOR: Hill Funeral Home — ADDRESS: Salisbury, Maryland
25a. REC'D BY REGISTRAR: DATE OCT 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Jordan

VR A15 (4) 25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1-1288 1-1393

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glenarden Md.
c. LENGTH OF STAY IN 1b: 11 Sept 1967
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 7912 Echols

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Wash.
b. COUNTY: D. C
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: 1440 W St N.W Apt 18
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wilbert Middle James Last Smith
4. DATE OF DEATH: Month Oct Day 16 Year 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 18, 1900
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardening
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Sampson County N.C.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Mathew James Smith
14. MOTHER'S MAIDEN NAME: Mary Margie Dixon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 578-14-1691
17. INFORMANT: Mrs Gertie B. Smith Address: 7912 Echols Glenarden Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X
DUE TO (b) Arteriosclerosis — 10 Years
DUE TO (c) Heart disease — 5 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 Oct, 1967, to 16 Oct, 1967, that (I) (we) last saw the deceased alive on 15 Oct 1967, and that death occurred at 9:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Ronald P. Hairston M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 16 Oct 67
22c. PHYSICIAN'S NAME (Type): Ronald P. Hairston
22d. ADDRESS: 3302 Hayes Glenarden Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-20-67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park
23d. LOCATION (City, town or county) (State): Prince Georges Cty. Md.

24. FUNERAL DIRECTOR: John T. Rhines Co Funeral Home ADDRESS: 3015 12th St., N.E.
25a. REC'D BY REGISTRAR DATE: OCT 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cremation John T. Rhines M.D. Lynn Mallinson

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14289 Item #9 Film #G393 10/10/67 ph

CERTIFICATE OF DEATH

14394

1 PLACE OF DEATH a. COUNTY: PRINCE GEORGES MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AF BASE

c. LENGTH OF STAY IN 1b: 3 Mos 7 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF HOSPITAL ANDREWS

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: VIRGINIA b. COUNTY: FAIRFAX

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SPRINGFIELD

d. STREET ADDRESS: 7100 ORIOLE AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LUEBERTHA Middle: JANNETTE Last: SONNENBURG

4 DATE OF DEATH Month: OCTOBER Day: 2 Year: 1967

5 SEX: FEMALE

6 COLOR OR RACE: CAU

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 19 NOV 1910

9 AGE (In years last birthday): 57 56 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSE

10b. KIND OF BUSINESS OR INDUSTRY: US. AIR FORCE

11 BIRTHPLACE (County & State or foreign country): FT SCOTT, KANSAS

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES W. BROWN

14. MOTHER'S MAIDEN NAME: BERTHA D. HULSEBUS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 321-34-2221

17 INFORMANT: HUSBAND Address: SAME AS #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARCINOMATOSIS FROM OVARY

1750

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a m p m 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 Jul, 1967, to 2 Oct, 1967 that (I) (we) last saw the deceased alive on 2 Oct 1967 and that death occurred at 5:45 AM from causes and on the date stated above

22a. SIGNATURE: Robert E. Harris

ATTENDING PHYS. ☐ MD MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2 Oct 67

22c. PHYSICIAN'S NAME (Type): ROBERT E. HARRIS, CAPTUSAF MC

22d. ADDRESS: USAF HospitalAndrews Andrews AFB, Wash DC 20331

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 10/7/1967

23c NAME OF CEMETERY OR CREMATORY: National Memorial Park

23d LOCATION (City or Town) (County) (State): Falls Church, Virginia

24. FUNERAL DIRECTOR: Ives Funeral Home

ADDRESS: 2847 Wilson Blvd. Arlington, Virginia

25a REC'D BY REGISTRAR DATE: OCT 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4390 Items #8 & 9 filed 73394 10/27/67 ph

CERTIFICATE OF DEATH

14395

1 PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): 4025 36th Street Mt. Rainier
d. STREET ADDRESS: 4025 36th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George Middle: W Last: Speckman
4. DATE OF DEATH: Month: Oct. Day: 15 Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6 July 1888
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM F. SPECKMANN
14. MOTHER'S MAIDEN NAME: MARIE B. LEDERER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): *******
16. SOCIAL SECURITY NO: 217-30-2456
17. INFORMANT: BERNICE M. SPECKMAN WIFE Address: SAME AS # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral thrombosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug, 1967, to Oct 15, 1967 that (I) (we) last saw the deceased alive on Oct 14 1967, and that death occurred at 5:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: Don B Cameron M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Oct 15, 1967
22c. PHYSICIAN'S NAME (Type): DON B. CAMERON
22d. ADDRESS: 3503 PERRY ST MT RAINIER MD

23a. BURIAL, CREMATION REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-18-67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor, Maryland

24. FUNERAL DIRECTOR: GASCH'S ADDRESS: HYATTSVILLE, MARYLAND
25a. REC'D BY REGISTRAR DATE: OCT 19 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14391 14396

1 PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5712 - 66th. Ave., Riverdale, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
d. STREET ADDRESS 5712 - 66th. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Thomas Last: Speer
4. DATE OF DEATH Month: October Day: 8 Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 6, 1928
9. AGE (in years last birthday): 39 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY: Law
11. BIRTHPLACE (County & State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Thomas Speer Sr.
14. MOTHER'S MAIDEN NAME: Elsie Klinehause
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Josephine Speer - Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) and Adenocarcinoma of colon (two separate malignancies)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 9 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 23 March, 19 67 to 8 October 19 67 that (I) (we) last saw the deceased alive on 19 August 1967, and that death occurred at 3:20 p.m. from causes and on the date stated above.

22a. SIGNATURE J. Richard Compton M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 9 October 67
22c. PHYSICIAN'S NAME (Type) J. Richard Compton, M.D.
22d. ADDRESS 612 Main Street, Laurel, Md 20810

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Oct 11, 1967
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE OCT 11 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical examiner notified and approved Dr John Kehoe Pro George's County Md.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14392 — 14397

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL-Upper Marlboro
c. LENGTH OF STAY IN 1b: 4-yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RFD Box 2575-Brown Station Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL-Upper Marlboro
d. STREET ADDRESS: RFD Box 2575-Brown Sta.Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Mary — Last: Squibb

4. DATE OF DEATH: Month: October — Day: 19 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 11, 1902

9. AGE (in years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Franklin Fernwald

14. MOTHER'S MAIDEN NAME: Matilda (nee Kreitz)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ------

16. SOCIAL SECURITY NO.:

17. INFORMANT: Warren S. Squibb-Same as Item #2. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b) GENERALIZED ARTERIOSCLEROSIS — 3 yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

☒ I certify that (I) (this hospital) attended the deceased from JAN. 1, 1940 to Oct. 19, 1967 that (I) (☐) last saw the deceased alive on Oct. 19, 1967, and that death occurred at 11:30 PM, from the causes and on the date stated above

22a. SIGNATURE: William J. P. Howard M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/19/67

22c. PHYSICIAN'S NAME (Type): William J. P. Howard, M.D.

22d. ADDRESS: 1331 Staples St. NE Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/24/67

23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Protestant Episcopal Cemetery

23d. LOCATION (City, town or county) (State): Union Township, Berks County, Penna.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ritchie Bros. Fun'l Home-Upper Marlboro, Md.

25a. REC'D BY REGISTRAR: OCT 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
2DM 5-63

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14398

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3128 Laurel Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
d. STREET ADDRESS: 3128 Laurel Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur Middle: Leonard Last: Stack
4. DATE OF DEATH: Month: Oct Day: 10 Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 14, 1901
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Balt. Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Garrett Stack
14. MOTHER'S MAIDEN NAME: Rosa A. Lydd Ave
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.
DUE TO (b) Cerebral Arteriosclerosis — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cirrhosis of Liver
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/10, 1967 to 10/10, 1967, that (I) (we) last saw the deceased alive on 10/10, 1967, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Norman D. Comeau M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/10/67
22c. PHYSICIAN'S NAME (Type): Norman D. Comeau
22d. ADDRESS: 3503 Perry St Mt Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons Hyattsville, Md. ADDRESS
25a. REC'D BY REGISTRAR DATE: OCT 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 1/65

1

MA67-13
1394

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1-1399

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: Prince George MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c LENGTH OF STAY IN 1b: 6 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Prince George
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Ranier
d STREET ADDRESS: 2701 Webster St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edmund Middle: A Last: Stahl
4. DATE OF DEATH: Month: October Day: 8 Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/26/~~22~~ 1921
9. AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b KIND OF BUSINESS OR INDUSTRY: Supply
11. BIRTHPLACE (County & State, or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Stahl, Aalexander
14. MOTHER'S MAIDEN NAME: Ronnberg, Ann
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 104-01-2968
17 INFORMANT: Hospital Record Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b): Severe fatty change of liver — 3-6 months
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure, anemia, alcoholism
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE, 1967 to 8 OCT, 1967, that (I) (we) last saw the deceased alive on 8 OCT. 1967, and that death occurred at 9:15 PM, from causes and on the date stated above

22a SIGNATURE: C. J. Houmann
M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 10-8-67
22c PHYSICIAN'S NAME (Type): C. J. HOUMANN
22d ADDRESS: RIVERDALE MD

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b DATE THEREOF: 10/10/67
23c NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cem.
23d LOCATION (City or Town) (County) (State): Colmar Manor, Md.
24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc. ADDRESS: Mt. Rainier Maryland
25a RECD BY REGISTRAR DATE: OCT 13 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14400

14395

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,
c. LENGTH OF STAY IN 1b 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D C
d. STREET ADDRESS 3009 Douglas Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Stubbs, Harry E
4. DATE OF DEATH Month October Day 8, Year 1967
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 4/24/97
9. AGE (In years last birthday) 70 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY WSSC
11. BIRTHPLACE (County & State, or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Stubbs, Prince
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Admitting Record Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO (b) PERFORATION OF ANASTOMOSIS (GASTRIC RESECTION)
DUE TO (c) CARCINOMA OF STOMACH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 3-4 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on 10/8 1967, and that death occurred at 7:15 A.M., from causes and on the date stated above.

22a. SIGNATURE R Wilkinson M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 10/12/67
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State) Washington, D.C.

24. FUNERAL DIRECTOR Stewart Hoover Funeral Home ADDRESS
25a. REC'D BY REGISTRAR DATE OCT 11 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4395 Items #13 & 14 Film #G393 10/16/67 ph

CERTIFICATE OF DEATH

14401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Magnolia Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, Md.
d. STREET ADDRESS: 5303 41th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emily Middle: J. Last: Suess
4. DATE OF DEATH: Month: October Day: 8 Year: 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1890
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William F. ~~Jacobs~~ Jacobi
14. MOTHER'S MAIDEN NAME: Alice ~~Moore~~ Maud Smith

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Anthony W Suess Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Hypertension Arot Disease
DUE TO (c): Arteriosclerotic Hart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4300
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Aug 8, 196 7, to Oct 7, 196 7, that (I) (~~we~~) last saw the deceased alive on 10 6 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: A. Deitz
MD ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-9 67
22c. PHYSICIAN'S NAME (Type): A Deitz
22d. ADDRESS: Pro Geo Plaza Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Juergen

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #3393 10/17/67 ph

4397

CERTIFICATE OF DEATH

14402

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Hyattsville~~ Mt. Rainier
d. STREET ADDRESS: 4227 29th Street ~~Carroll Manor Nursing Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patrick — Middle: J. — Last: Swift
4. DATE OF DEATH: Month: Oct. — Day: 6 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/23/75
9. AGE (In years last birthday): 91 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Bricklayer
11. BIRTHPLACE (County & State, or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ? Swift
14. MOTHER'S MAIDEN NAME: Mary McHale
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 577-18-0424
17. INFORMANT: A — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): THROMBOSIS, Left Middle — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cerebral artery — 9 Days
DUE TO (c): ARTERIOSCLEROSIS, GENERALIZED — 1 YEAR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BRONCHOPNEUMONIA, BOTH LUNGS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN 1, 1966, to OCT 6, 1967, that (I) (we) last saw the deceased alive on OCT 6 1967, and that death occurred at 12:30 AM, from causes and on the date stated above.

22a. SIGNATURE: Samuel J. N. Sugar M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Oct 6 67
22c. PHYSICIAN'S NAME (Type): Smauel J.N. Sugar, M..D.
22d. ADDRESS: 4637 Eastern AVe.. WAshington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/10/67
23c. NAME OF CEMETERY OR CREMATORY: St. Patrick Cemetery
23d. LOCATION (City or Town) (County) (State): Blakeley, Penna.

24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc. — ADDRESS: Mt. Rainier, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Yuzer

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

74398

CERTIFICATE OF DEATH

14403

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 5808 Rittenhouse St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: F — Last: Talley

4. DATE OF DEATH: Month: Oct — Day: 14 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 20 Aug., 1906
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Policeman
11. BIRTHPLACE (County & State, or foreign country): Belgrade Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob M. Talley
14. MOTHER'S MAIDEN NAME: Ellen Hays

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 510-14-6415
17. INFORMANT: Anna P. Talley — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (b) Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) (a) Cardiac Arrest.
DUE TO (c) (c) Congestive Heart Failure.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-9th, 1967, to 10-14th, 19 67, that (I) (we) last saw the deceased alive on 10-14th 1967, and that death occurred at 8, 30PM from causes and on the date stated above.

22a. SIGNATURE: Hernandez MD — M.D. ☐ ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10/15/1967
22c. PHYSICIAN'S NAME (Type): P. J. HERNANDEZ, MD
22d. ADDRESS: Prince Geo. Gen. Hosp.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-18-1967
23c. NAME OF CEMETERY OR CREMATORY: National
23d. LOCATION (City or Town) (County) (State): Culpepper, Va

24. FUNERAL DIRECTOR: Mathews — ADDRESS: 131-11th St. S.E. D.C.
25a. RECD BY REGISTRAR DATE: OCT 17 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper/s. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14398

CERTIFICATE OF DEATH

14404

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AF BASE
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MALCOLM GROW USAF HOSPITAL

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OXON HILL
d. STREET ADDRESS: 1409 SOUTHERN AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHAW — Middle EDWARD — Last TATE
4. DATE OF DEATH: Month OCTOBER — Day 20 — Year 1967
5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 Oct 67
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months — Days 9 — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA
10b. KIND OF BUSINESS OR INDUSTRY: NA
11. BIRTHPLACE (County & State, or foreign country): PRINCE GEORGES, MD.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ROBERT TERRILL TATE
14. MOTHER'S MAIDEN NAME: ALVA JEAN JOHNSTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): NA
16. SOCIAL SECURITY NO: NA
17. INFORMANT: MOTHER — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH
2403
DUE TO
(b) MENNINGITIS & SEPSIS — 14 hrs
~~DUE TO~~
(c) MULTIPLE CARDIAC ARRYTHMIAS — 7 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CONGENITAL SUPRA-VENTRICULAR TACHYCARDIA, ATRIAL FLUTTER
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): No
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12 Oct, 1967, to 20 Oct, 1967, that (I) (we) last saw the deceased alive on 20 Oct 1967, and that death occurred at 3:35 AM, from causes and on the date stated above

22a. SIGNATURE: Richard W. Dodds M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 20 Oct 67
22c. PHYSICIAN'S NAME (Type): RICHARD W. DODDS, CAPT, USAF, MC
22d. ADDRESS: Malcolm Grow USAF Hospital Andrews AFB, Wash DC 20331

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/23/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Gillian Cemetery
23d. LOCATION (City or Town) (County) (State): Eclectic, Alabama

24. FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home
ADDRESS: 4308 Suitland Road, Suitland, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Jordan

7-20744-3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14409 — 14405

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 2 hr.55 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 5124 Mangum Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia — Middle: Flippo — Last: Tatman
4. DATE OF DEATH: Month: October — Day: 25 — Year: 19 67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 24, 1903
9. AGE (In years last birthday): 64 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nutritionist(retired)
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Dept.Agriculture
11. BIRTHPLACE (County & State, or foreign country): Millboro, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Flippo E. R.
14. MOTHER'S MAIDEN NAME: Laura Bell Bratton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215 26 2920
17. INFORMANT: hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Left Hemiplegia
DUE TO (c): General arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1944, 19__ to Oct 25, 1967, that (I) (we) last saw the deceased alive on Oct 25 1967, and that death occurred at 5-03 P.M. from causes and on the date stated above.

22a. SIGNATURE: L W Malin M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): L.W. MALIN MD.
22d. ADDRESS: Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 27, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14401 — 14406

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AF BASE
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FALLS CHURCH
d. STREET ADDRESS: 3401 FIDDLERS GREEN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ELLEN — Last: TAYLOR
4. DATE OF DEATH: Month: OCTOBER — Day: 3 — Year: 1967
5. SEX: FEMALE
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7 APRIL 1922
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NA
11. BIRTHPLACE (County & State, or foreign country): PUYALLUP, WASH.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: WILLIAM BENTHIEN
14. MOTHER'S MAIDEN NAME: LILLIAN BREFFIT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): NA
16. SOCIAL SECURITY NO.: 535-12-8379
17. INFORMANT: HUSBAND — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Respiratory Insufficiency
DUE TO (b): Chronic Obstructive Pulmonary
DUE TO (c): Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 Sept, 1967 to 3 Oct, 1967, that (I) (we) last saw the deceased alive on 3 Oct 1967, and that death occurred at 7:23 AM, from causes and on the date stated above.

22a. SIGNATURE: John F. Lindeman M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3 Oct 67
22c. PHYSICIAN'S NAME (Type): JOHN F. LINDEMAN, CAPT, USAF, MC
22d. ADDRESS: Andrews AFB, Wash DC 20331 USAF Hospital Andrews

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-9-67
23c. NAME OF CEMETERY OR CREMATORY: Old Takoma Cemetery
23d. LOCATION (City or Town) (County) (State): Takoma, Wash.

24. FUNERAL DIRECTOR: David L. Jones — ADDRESS: Murphy Funeral Home Arlington, Va.
25a. REC'D BY REGISTRAR: OCT 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

14402

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14407

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 518 L St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irma — Middle: C. — Last: Thomas
4. DATE OF DEATH: Month 10 - Day 17 - Year 19 67
5. SEX: F
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/14/23
9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William T. Wiggins
14. MOTHER'S MAIDEN NAME: Olga Noble
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: decedent — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of tonsil with metastases — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year 19 — Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/13/ 167, to 10/17/ 1967, that (I) (we) last saw the deceased alive on 10/17/ 19 67, and that death occurred at 11:15AM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 10/17/67
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-21-67
23c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEM.
23d. LOCATION (City or Town) (County) (State): SUITLAND, MD.
24. FUNERAL DIRECTOR: BARNES & MATTHEWS — ADDRESS: WASHINGTON, D.C. 3649-14 ST. N.W.
25a. REC'D BY REGISTRAR — DATE: OCT 23 1967
25b. REGISTRAR'S SIGNATURE: R. Charles Judge

VR A15 (4)
25M 1/67

1 14403

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14408

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Prince Georges — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 4682 Homer Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: E. — Last: Trammell
4. DATE OF DEATH: Month: Oct. — Day: 18, — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/10/05
9. AGE (In years last birthday): 62 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARBER
10b. KIND OF BUSINESS OR INDUSTRY: BARBER SHOP
11. BIRTHPLACE (County & State, or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: VAINCE TRAMMELL
14. MOTHER'S MAIDEN NAME: OLE HOGAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 577-10-8202
17. INFORMANT: Sadie Trammell — Address: 4682 Homer Ave Suitland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident.
DUE TO (b): Acute Myocardial Infarction.
DUE TO (c): Arteriosclerotic Cardiovascular Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4701
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 8, 19 67, to Oct. 18, 19 67, that (I) (we) last saw the deceased alive on Oct. 18, 1967, and that death occurred at 8:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: Thomas J. Hernandez M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: Oct. 18, 1967
22c. PHYSICIAN'S NAME (Type): Tomas J. Hernandez, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT. 21 1967
23c. NAME OF CEMETERY OR CREMATORY: WASH. NATIONAL CEM
23d. LOCATION (City or Town) (County) (State): SUITLAND MARYLAND
24. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: Riverdale, Md. — W.W. Chambers Co 5801 CLEVELAND AVE RIVERDALE
25a. REC'D BY REGISTRAR: DATE OCT 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 25M 1/67

1

14405

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14410

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORESTVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): REGENT NSG HOME

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COLONIAL BEACH
d. STREET ADDRESS: 213 DENNESON
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle E. Last VAN DEUSEN
4. DATE OF DEATH: Month October Day 14 Year 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 10-28-72
9. AGE (In years last birthday): 94 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Health
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM A. VAN DEUSEN
14. MOTHER'S MAIDEN NAME: MARY A. HITCHENS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. ANN F. VAN DEUSEN — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): A.S.H.D. — many years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/21, 1967 to 10/14, 1967, that (I) (we) last saw the deceased alive on 10/13, 1967, and that death occurred at 7:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: Henry J Palacios — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): HENRY J PALACIOS
22d. ADDRESS: 8000 Indian Head Hwy Oxon Hill Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/17/1967
23c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove Cemetery
23d. LOCATION (City or Town) (County) (State): Herndon Virginia
24. FUNERAL DIRECTOR: Ives Funeral Home — ADDRESS: 2847 Wilson Blvd Arl Va
25a. REC'D BY REGISTRAR DATE OCT 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13605

CERTIFICATE OF DEATH

14411

1 PLACE OF DEATH a. COUNTY: Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly

c. LENGTH OF STAY IN 1b: 1 DAY

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE: Maryland b. COUNTY: Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park

d. STREET ADDRESS: 4614 Drexel Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Frank Middle: Last: Vrana Jr

4. DATE OF DEATH Month: October Day: 20, Year: 1967

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/5/11

9 AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookbinder

10b KIND OF BUSINESS OR INDUSTRY: U S Government

11 BIRTHPLACE (County & State, or foreign country): Ohio

12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: Frank Vrana

14. MOTHER'S MAIDEN NAME: Stella Sykora

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT: Anne Vrana Address: College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia

DUE TO (b): Metastatic Ca of the brain

DUE TO (c): Ca of the lung

160X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from April 5, 1967, to Oct 20, 1967, that (I) (we) last saw the deceased alive on Oct 20 1967, and that death occurred at 2:05 PM, from causes and on the date stated above.

22a. SIGNATURE M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED 10-21-67

22c. PHYSICIAN'S NAME (Type): John R. Lilly, M. D.

22d. ADDRESS: 4410 74th Ave. Bellmead, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b DATE THEREOF: Oct 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Crematory

23d LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE OCT 25 1967

25b REGISTRAR'S SIGNATURE Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1440S

CERTIFICATE OF DEATH

14412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b COUNTY: Prince Georges
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jefferson Heights
d STREET ADDRESS: 1006 65th Place
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Baby Middle: Girl Last: Walker
4 DATE OF DEATH: Month: Oct., Day: 14 Year: 19 67
5 SEX: Female
6 COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9 Oct., 1967
9 AGE (In years lost birthday): yrs; IF UNDER 1 YEAR: Months, Days 5; IF UNDER 24 HRS: Hours, Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State, or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ☒ Edgar Walker
14. MOTHER'S MAIDEN NAME: Victoria Furr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17 INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Prematurity (720 grams)
DUE TO (b) Atelectasis of lungs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
762.5
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 9, 1967 to Oct. 14, 1967, that (I) (we) last saw the deceased alive on Oct. 14, 1967, and that death occurred at 4:50 AM, from causes and on the date stated above.

22a. SIGNATURE: Hugh Clark M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Hugh Clark, M. D.
22d. ADDRESS: Prince Georges General Hospital

23a BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF: 11-4-67
23c NAME OF CEMETERY OR CREMATORY: Prince George's Hospital
23d LOCATION (City or Town) (County) (State): Cheverly, Maryland
24. FUNERAL DIRECTOR: HARRY W. PENN, JR. ADDRESS: Cheverly, Maryland
25a FILED BY REGISTRAR DATE: NOV 7 1967
25b REGISTRAR'S SIGNATURE: Florence Judge

VR A15 (4) 25M 1/67

7-2797

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14413

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: about 2½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 6213 20th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: — Last: Ward
4. DATE OF DEATH: Month: 10 — Day: 22 — Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-23-43
9. AGE (In years last birthday): 24 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): auto mechanic
10b. KIND OF BUSINESS OR INDUSTRY: mechanics
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Roger Ward
14. MOTHER'S MAIDEN NAME: Elissa Stauted
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a): perforating gunshot wound of abdomen
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): shot by policeman during arrest attempt
20c. TIME OF INJURY: Hour: 3:05 a.m. p.m. — Month Day, Year: 10-19 1967
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.): 4100 Powdermill Rd.,
20f. (City or town): Beltsville, (County): P.G. (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland — Address (Street, city, town, or county):
22. DATE SIGNED: 10-2[illegible]-67

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 10/24/1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY
23d. LOCATION (City or Town): SUITLAND, (County): (State): MARYLAND

24. FUNERAL DIRECTOR: HYSONG'S FUNERAL HOME — ADDRESS: 1300 H. STREET, N.W.—WASH. D.C.
25a. RECD BY REG STRAR: DATE OCT 24 1967
25b. REG STRAR'S SIGNATURE: [illegible] Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1 '67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14409

14414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Conn.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Haven
d. STREET ADDRESS: 338 Orange St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine — Middle: Carroll — Last: Wardell

4. DATE OF DEATH: Month: 10 — Day: 4 — Year: 1967

5. SEX: Female — White Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 13 May 1896

9. AGE (In years last birthday): 71 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): New Haven, Conn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Carroll

14. MOTHER'S MAIDEN NAME: Mary Mannix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ———

16. SOCIAL SECURITY NO:

17. INFORMANT: Address: Sisk F.H., New Haven, Conn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (b) Arteriosclerotic heart disease — over 1 yr.

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Aneurysm of thoracic and abdominal aorta - over 1 year.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.

22. DATE SIGNED: 10-5-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/7/67

23c. NAME OF CEMETERY OR CREMATORY: St. Lawrence Cem.

23d. LOCATION (City or Town) (County) (State): New Haven, Conn.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons — ADDRESS: 5130 Wis. Ave. NW, Washington, D.C.

25a. RECD BY REGISTRAR — DATE: OCT 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14409 14415

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
c. LENGTH OF STAY IN 1b: 2 Mos., 14 Da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PINE VIEW GARDENS, CLINTON MD

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: Box 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First LAURA Middle Rebecca Last WATSON
4 DATE OF DEATH: Month October Day 19 Year 1967
5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 1-11-75
9 AGE (In years last birthday): 92 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (County & State, or foreign country): PRINCE GEORGE, Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: George W. Smith
14 MOTHER'S MAIDEN NAME: Josephine Boswell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --
16. SOCIAL SECURITY NO. 216-22-0279
17. INFORMANT: Joseph C. Watson-Same as Item #2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Arteriosclerotic Cardiovascular disease 3 Days
DUE TO (c): Senility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-8, 1967, to 10-19, 1967, that (I) (we) last saw the deceased alive on 10-19-67, 19__, and that death occurred at 2:30 p.m. from causes and on the date stated above.

22a. SIGNATURE: Alfred R. Lapin, M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 10/19/67
22c PHYSICIAN'S NAME (Type): ALFRED R. LAPIN, MD
22d. ADDRESS: CLINTON, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/21/67
23c NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
23d. LOCATION (City or Town) (County) (State): Upper Marlboro Md.
24. FUNERAL DIRECTOR: Ritchie Bros. Upper Marlboro, Md.
ADDRESS
25a REC'D BY REGISTRAR DATE OCT 30 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

144.9

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14416

1 PLACE OF DEATH
a. COUNTY: Prince Geoege — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN Ib: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
d. STREET ADDRESS: 12002 Gordon Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oliver — Middle: W — Last: Weekley
4. DATE OF DEATH: Month: 10 — Day: 14 — Year: 19 67

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12 Mar., 1925
9. AGE (In years last birthday): 42 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Officer
10b KIND OF BUSINESS OR INDUSTRY: Pro Geo County
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: James H Weekley
14 MOTHER'S MAIDEN NAME: Mary B Wright

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): W W II
16 SOCIAL SECURITY NO.: 578 22 0721
17 INFORMANT: Lois Weekley — Address: Beltsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Arteriosclerotic heart disease — Unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D., Riverdale, Md.
Address (Street, city, town, or county)
22. DATE SIGNED: 1-15-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 18, 1967
23c NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a REC'D BY REGISTRAR: DATE OCT 19 1967
25b REGISTRAR'S SIGNATURE: Charles Juggle

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1-1417

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PRINCE GEORGE'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 5061 NEW HAMPSHIRE AV
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle Last WELCH
4. DATE OF DEATH: Month OCT Day 16, Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: OCT 29 1892
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE, BOOK KEEPER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: ENGLEBERT BECKER
14. MOTHER'S MAIDEN NAME: CAROLINE HAASLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 359 160185
17. INFORMANT: MRS RUTH L. VEITH — Address: 3204 TOLEDO PLACE APT 202 HYATTSVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary Thrombosis — 1 day
DUE TO (c) Arteriosclerosis of Coronary arty — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1965, to 10-16, 1967, that (I) (we) last saw the deceased alive on 10-13 1967, and that death occurred at _____ M, from the causes and on the date stated above.

22a. SIGNATURE: Donald C. Edgren M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-19-67
22c. PHYSICIAN'S NAME (Type): DONALD C. EDGREN
22d. ADDRESS: Aquatusk, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: OCT 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CREMATORY
23d. LOCATION (City, town or county) (State): COLMAR MANOR, MD

24. FUNERAL DIRECTOR: W. W. CHAMBERS CO — ADDRESS: RIVERDALE, MD
25a. REC'D BY REGISTRAR DATE OCT 20 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
2DM 1/65

1

[redacted] DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4412 — 14118

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANHAM
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Magnolia Gardens

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d. STREET ADDRESS: 8610 MAPLE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James, Middle Edward, Last Wildman SR.

4. DATE OF DEATH: Month Oct, Day 5, Year 1967

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 25 Nov. 1883
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator
10b. KIND OF BUSINESS OR INDUSTRY: Western Union
11. BIRTHPLACE (County & State, or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James G. Wildman
14. MOTHER'S MAIDEN NAME: — Dennison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elizabeth Wildman — Address: Dau. Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ch. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

4222

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 19..., to Oct 5 19 67, that (I) (we) last saw the deceased alive on Oct 5 1967, and that death occured at 8:32 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert S. McCeney, M.D.
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): ROBERT S. McCENEY, M. D.
402 MAIN ST.
LAUREL, MARYLAND 20810
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct 9, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Holy Trinity Cemetery
23d. LOCATION (City, town or county): Collington Pro Geo — (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR — DATE: OCT 9 1967 — REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

4 1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14413

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14419

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b COUNTY: Prince George's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
d STREET ADDRESS: 7076 Hanover Parkway
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Clarence — Middle: Wallace — Last: Williams
4 DATE OF DEATH: Month: 10 — Day: 29 — Year: 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 6 April 1914
9 AGE (In years ost birthday): 53 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISABLED VETERAN
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): VIRGINIA
12 CITIZEN OF WHAT COUNTRY? U.S.
13 FATHER'S NAME: UNKNOWN
14 MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war, or dates of service): W.W. II
16 SOCIAL SECURITY NO: 229-12-0653
17 INFORMANT (Address): GEORGE B. WILLIAMS, 7078 HANOVER PARKWAY, GREENBELT, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Arteriosclerotic heart disease — over 1 yr.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
+200

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 10-30-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: NOV 2, 1967
23c NAME OF CEMETERY OR CREMATORY: CITY POINT NATIONAL
23d LOCATION (City or Town) (County) (State): HOPEWELL, VIRGINIA
24. FUNERAL DIRECTOR: W.W. CHAMBERS CO.
ADDRESS: RIVERDALE, MD
25a RECD BY REGISTRAR DATE: NOV 2 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN 1b: 30 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 47 A STREET

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 47 A Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: LOUIS Last: williams

4. DATE OF DEATH: Month: Oct Day: 10 Year: 1967

5. SEX: male
6. COLOR OR RACE: white.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 1, 1891
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): used furniture dealer
10b. KIND OF BUSINESS OR INDUSTRY: self-employed
11. BIRTHPLACE (County & State, or foreign country): Washington, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James William
14. MOTHER'S MAIDEN NAME: Laura Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Annie Williams Address: 47 A St. Laurel Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO (b) Coronary thrombosis
DUE TO (c) Coronary arteriosclerosis x Chronic Cardiac Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-13, 1966, to 10-10, 1967, that (I) (we) last saw the deceased alive on 10-10, 1967, and that death occurred at 8:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Adlo Pierandrei M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-10-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-13-67
23c. NAME OF CEMETERY OR CREMATORY: Savage Cem.
23d. LOCATION (City or Town) (County) (State): Savage Md.

24. FUNERAL DIRECTOR: Ile Witt Donaldson ADDRESS: Laurel Md
25a. REC'D BY REGISTRAR DATE OCT 17 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14415

CERTIFICATE OF DEATH

14421

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Savage
d. STREET ADDRESS: Box 24
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: H. — Last: Williamson
4. DATE OF DEATH: Month: October — Day: 2 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-26-[redacted]15
9. AGE (In years ost birthday): [redacted] 52 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bottler
10b. KIND OF BUSINESS OR INDUSTRY: distillery
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henderson, William
14. MOTHER'S MAIDEN NAME: Annie Giles
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Husband/Medical Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocarditis — 3 days
DUE TO
(b) Chr. Myocarditis — 11 yr
DUE TO
(c) Hypertension — 4 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
I.45 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year — Hour: a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 28, 1956 to 10/2/67, 19___, that (I) (we) last saw the deceased alive on 10/1 1967, and that death occurred at 10:45 A.M., from causes and on the date stated above

22a. SIGNATURE: Robert S. McCeney M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): ROBERT S. McCENEY, M. D.
402 MAIN ST.
LAUREL, MARYLAND 20810
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/5/67
23c. NAME OF CEMETERY OR CREMATORY: Maryland Memorial Gardens
23d. LOCATION (City or Town) (County) (State): New Park Laurel Md
24. FUNERAL DIRECTOR: [illegible]
ADDRESS: Laurel Md.
25a. REC'D BY REGISTRAR: DATE OCT 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

14416

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14422

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, fill in Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 10 Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5209 57th. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First James — Middle Elwood — Last Wilson
4 DATE OF DEATH: Month 10 — Day 16 — Year 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 7-23-1921
9 AGE (In years last birthday): 46 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b KIND OF BUSINESS OR INDUSTRY: U S Government
11 BIRTHPLACE (State or foreign country): Missouri
12 CITIZEN OF WHAT COUNTRY? U S A
13 FATHER'S NAME: Thomas Wilson
14 MOTHER'S MAIDEN NAME: Maude Smith
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 1942 to 1962
16 SOCIAL SECURITY NO: 442 14 0915
17 INFORMANT: Marjorie C Wilson — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Following surgery for peritonitis — 6 days
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver of car which hit a tree.
20c TIME OF INJURY Month, Day, Year — Hour 12:05am/pm 10-10- 19 67
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.): 5000 block Edmonston Rd.
20f (City or town) Bladensburg, (County) (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John Kehoe, M.D. — Address (Street, city, town or county): Riverdale, Md.
22. DATE SIGNED: 10-17-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 19, 1967
23c NAME OF CEMETERY OR CREMATORY: Arlington National
23d LOCATION (City or Town) Arlington (County) Virginia (State)

24 FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a REC'D BY REGISTRAR: OCT 20 1967
25b REGISTRAR'S SIGNATURE

VR A15ME (5) 6M 1/67

Item 20&21 Film 397
2-2-68 ams
1447

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film 3397 2/19/68 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14423

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 919 Lemma Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First [redacted] Middle Paul Gladdis Last Wilson
4 DATE OF DEATH: Month 10 Day 30 Year 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARITAL STATUS: NEVER MARRIED ☐ W.DOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: 4-18-1920
9 AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Tenn.
12 CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: George Wilson
14. MOTHER'S MAIDEN NAME: Rosie Bales
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W.W.II
16 SOCIAL SECURITY NO: 413-14-1650
17 INFORMANT: (Sister) Address: Balto, Md
Mrs Myntle Pratt, 942 W. Lombard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural Hematoma
DUE TO Trauma.
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
936.7
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (For [illegible] of [illegible] in Part I or Part II of item 18): Undetermined
20c TIME OF INJURY Month, Day Year: Hour P.M. 10-22 67
While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, factory, street, office bldg., etc.): Undetermined
20f (City or town) Bowie (County) Pr.Geo. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Riverdale, Md.
22. DATE SIGNED: 11-2-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11/6/67
23c NAME OF CEMETERY OR CREMATORY: Roseberry
23d LOCATION (City or Town) Knox (County) County (State) Tenn.
24. FUNERAL DIRECTOR: W.W. Chambers Co. Inc. ADDRESS: 1400 Chapin St. N.W. Wash. D.C.
25a REC'D BY REGISTRAR: DATE NOV 6 1967
25b REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14419 Item #7 Film #G394 11/6/67 ph

14424

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
LENGTH OF STAY IN 1b: 10/12/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Regent Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 11 Seaton Place N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Daniel Last: Wilson
4. DATE OF DEATH: Month: Oct. Day: 27, Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 10-15-96
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Elevator operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Augusta Co., Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jerry T. Wilson
14. MOTHER'S MAIDEN NAME: Louise Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
16. SOCIAL SECURITY NO: WWI 579-40-1646
17. INFORMANT: Mary L. Brown Address: 623 Pennsylvania Ave., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO (b) Myocardial Failure — 6 mo
DUE TO (c) Arteriosclerotic Cardiovascular Disease — 4-5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Cerebral Arteriosclerosis C.V.A. 1962, senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/12, 1967, to 10/27/1967, that (I) (we) last saw the deceased alive on 10/27/1967, and that death occurred at 12:05 P.M. from causes and on the date stated above

22a. SIGNATURE: Kelvin L. Minchin M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10/27/67
22c. PHYSICIAN'S NAME (Type): KELVIN L. MINCHIN
22d. ADDRESS: 6400 MARLBORO PIKE S.E.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-31-67
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Cemetery
23d. LOCATION (City or Town) (County) (State): Suitland, P. G., Maryland
24. FUNERAL DIRECTOR: Hall Bros. ADDRESS: 621 Florida Ave. N.W.
25a. REC'D BY REGISTRAR: DATE NOV 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1416 Item #7 Film #039, 10/30/67 ph

14425

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince george's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: 2101 16th Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Morris Middle Last Wolowitz
4. DATE OF DEATH: Month Oct. Day 20 Year 19 67
5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 25, 1878
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Business Machines
11. BIRTHPLACE (County & State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Wolf Wolowitz
14. MOTHER'S MAIDEN NAME: Esther —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 266-54-6423
17. INFORMANT: William H. Wolowitz — Address: 1742 Holly St. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS
DUE TO
(b) GASTRO INTESTINAL HEMORRHAGE — 10 DAYS
DUE TO
(c) GASTRIC ULCER — 10 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN 1, 1967 to OCT 20, 1967, that (I) (~~we~~) last saw the deceased alive on OCT 20 1967, and that death occurred at 8:15 PM, from causes and on the date stated above.

22a. SIGNATURE: Samuel J. N. Sugar — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Oct 20, 1967
22c. PHYSICIAN'S NAME (Type): Samuel J.N. Sugar
22d. ADDRESS: 4637 Eastern Ave. Washington 18, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/22/67
23c. NAME OF CEMETERY OR CREMATORY: Ohev Sholom-Talmud Torah Cem
23d. LOCATION (City or Town) (County) (State): Wash. D.C.
24. FUNERAL DIRECTOR: B. Naugansky & Sons — ADDRESS: 3501-14th Street Wash. D.C.
25a. REC'D BY REGISTRAR: DATE OCT 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give to funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4420 — 14426

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): UNIVERSITY PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4300 TUCKERMAN ST

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIVERSITY PARK
d. STREET ADDRESS: 4300 TUCKERMAN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALFRED Middle R. Last YANCEY
4. DATE OF DEATH: Month OCT Day 11 Year 1967
5. SEX: MALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 22 MARCH 1904
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUILDER
10b. KIND OF BUSINESS OR INDUSTRY: BUILDING
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME: EDWIN L. YANCEY
14. MOTHER'S MAIDEN NAME: EDITH. M. THORNTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 578287156
17. INFORMANT: MRS [redacted] YANCEY THEORA A. Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): Lymphosarcoma
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 28, 1967 to Oct 11, 1967, that (I) (we) last saw the deceased alive on Oct 10 1967 and that death occurred at 4 AM, from the causes and on the date stated above.

22a. SIGNATURE: Don B. Cameron M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-11-67
22c. PHYSICIAN'S NAME (Type): DON B. CAMERON
22d. ADDRESS: MT. RAINIER, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
23d. LOCATION (City, town or county) (State): CULPEPER, VIRGINIA

24. FUNERAL DIRECTOR: W. W. CHAMBERS Co. ADDRESS: RIVERDALE, MD.
25a. REC'D BY REGISTRAR DATE OCT 16 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4421

14427

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland 20781
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 6022 44th. Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ezra; Middle: J.; Last: Youmans
4. DATE OF DEATH: Month: 10; Day: 20; Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-9-97
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier
10b. KIND OF BUSINESS OR INDUSTRY: Cab Company
11. BIRTHPLACE (County & State, or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Oliver Youmans
14. MOTHER'S MAIDEN NAME: Rosella Dickson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W W 1
16. SOCIAL SECURITY NO.: 212 12 2925
17. INFORMANT: Wife and Medical Records Department — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: ONE MONTH
DUE TO (b): ARTERIOSCLEROTIC AND RHEUMATIC — INTERVAL: UNKNOWN
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
CARDIO VASCULAR DISEASE

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9-25, 1967, to 10-20, 1967, that (I) (we) last saw the deceased alive on 10 20 1967, and that death occurred at 8:50 AM, from causes and on the date stated above.

22a. SIGNATURE: C. J. Houmann M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10.20.67
22c. PHYSICIAN'S NAME (Type): C J HOUMANN
22d. ADDRESS: RIVERDALE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 23, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14422

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14428

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN Ib: ten hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: Rte. 2, Box 153 Contee Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Andrew — Middle: — Last: Zalupsky

4 DATE OF DEATH: Month: 10 — Day: 6 — Year: 1967

5 SEX: male
6 COLOR OR RACE: white
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: 7-9-14
9 AGE (in years last birthday): 53 yrs
If UNDER 1 YEAR: Months: — Days: —
If UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Pennsylvania
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Stanley Zalupsky
14 MOTHER'S MAIDEN NAME: Elizabeth Penchosky

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: Mary Sharich — Address: 357 McCandless St, Arnold, Pa. 15068

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laceration of brain — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Trauma
DUE TO (c): Auto Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): pedestrian struck by car
20c TIME OF INJURY: Month, Day, Year — Hour: 4:32pm p.m. — 10-5 1967
20d INJURY OCCURRED: While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): U.S. Route 1, (near) Laurel, P.G., Md.
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Kehoe M.D.
EXAMINER'S NAME (Type): John Kehoe M.D., Riverdale, Maryland
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 10-8-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10-9-67
23c NAME OF CEMETERY OR CREMATORY: Savage Cemetery
23d LOCATION (City or Town) (County) (State): Savage Howard Md.

24 FUNERAL DIRECTOR: De Witt Donaldson
ADDRESS: Laurel Md
25a RECD BY REGISTRAR DATE: OCT 10 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14423 14429

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 2½ months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hyattsville Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington, D.C. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 4627 47th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle CADEI Last ZANDONINI
4. DATE OF DEATH: Month Oct. Day 4 Year 19 67
5. SEX: F
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 13, 1877
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ~~At Home~~
11. BIRTHPLACE (County & State, or foreign country): CHiari, Italy 1
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Faustino Cadei
14. MOTHER'S MAIDEN NAME: Maria Maggione
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ——
16. SOCIAL SECURITY NO.: 579-66-6019
17. INFORMANT: Elizabeth M. Zandonini, Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 weeks
491X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12-23-60, to 9-29-67 that (I) (we) last saw the deceased alive on 9-29-67, and that death occurred at 4:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: C P Ryland — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED 10-4-67
22c. PHYSICIAN'S NAME (Type): C P RYLAND — 22d. ADDRESS: 4400-49th St NW Wash DC 20016

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/9/67
23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, ADDRESS: 5130 Wis.Ave,NW,Wash.,D.C.
25a. REC'D BY REGISTRAR DATE OCT 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14424 Item #9 Film #G39h 11/6/67 ph

CERTIFICATE OF DEATH

14430

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 57 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4407 Vanburen St., University Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: D. — Last: Zentz
4. DATE OF DEATH: Month: October — Day: 24 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/7/1895
9. AGE (In years last birthday): 72 / 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Andrew L Huss
14. MOTHER'S MAIDEN NAME: Florence A. Reeder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ezra Monroe Zentz — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Nutritional cirrhosis of the Liver with
DUE TO (b) hepatic failure
DUE TO (c)

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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-15, 1964, to 10/24, 1967, that (I) (we) last saw the deceased alive on 10-23 1967, and that death occurred at 8:40 A.M. from causes and on the date stated above.

22a. SIGNATURE: Don B Cameron M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-24-67
22c. PHYSICIAN'S NAME (Type): Dr. Don B. Cameron
22d. ADDRESS: 3503 Perry St., Mt. Rainier, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 30 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
25M 1/67